

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
AT NASHVILLE**

JOHN B., CARRIE G., JOSHUA M., MEAGAN A.)
and ERICA A., by their next friend, L.A.;)
DUSTIN P. by his next friend, Linda C.;)
BAYLI S. by her next friend, C.W.;)
JAMES D. by his next friend, Susan H.;)
ELSIE H. by her next friend, Stacy Miller;)
JULIAN C. by his next friend, Shawn C.;)
TROY D. by his next friend, T.W.;)
RAY M. by his next friend, P.D.;)
ROSCOE W. by his next friend, K.B.;)
JACOB R. by his next friend, Kim R.;)
JUSTIN S. by his next friend, Diane P.;)
ESTEL W. by his next friend, E.D.;)
individually and on behalf of all others)
similarly situated,)

Plaintiffs,)

v.)

No. 3-98-0168

Judge Nixon

NANCY MENKE, Commissioner,)
Tennessee Department of Health;)
THERESA CLARKE, Assistant Commissioner)
Bureau of TennCare; and)
GEORGE HATTAWAY, Commissioner)
Tennessee Department of Children's Services)

Defendants.)

JULY 2001 SEMI-ANNUAL PROGRESS REPORT

Pursuant to Paragraph 104 of the Consent Decree entered on March 11, 1998, the state Defendants agreed to file a semi-annual report with this Court and plaintiffs' counsel regarding their compliance with the terms of this order. Such reports are to be filed on July 31st and January 31st of each year. Said reports "shall contain information, validated by the applicable

audit and testing procedures outlined herein, which accurately and fully reflect the status of the State's compliance with each of the applicable requirements of this order . . ."

Attached to this notice is a copy of the Semi-Annual Progress Report for the period ending July 31, 2001. Pursuant to paragraph 104 of the Consent Decree, this semi-annual report is being provided to plaintiffs' local counsel.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing document has been forwarded by first-class U.S. Mail, postage prepaid, to:

Gordon Bonnyman
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Nashville, Tennessee 37201
Counsel for Plaintiffs

on this, the 31st day of July, 2001.

John A. Bress

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JULY 2001 SEMI-ANNUAL PROGRESS REPORT

John B. Semiannual Progress Report

July 31, 2001

A number of important activities took place during the past six months on the *John B. Consent Decree*. These activities included infrastructure improvements both inside and outside of TennCare, as well as specific improvements in EPSDT outreach and informing, screening, diagnosis and treatment, monitoring, and coordination of effort. The summary of these activities provided on the following pages highlights the state's efforts to assure continuous improvement in EPSDT services to children.

On November 2, 2000, the Children with Special Needs Steering Panel overseeing the Remedial Plan met and determined that the diligent efforts that had been made to implement the May 2000 Remedial Plan were not achieving the desired results. They voted to try a new approach. On November 16, 2000, the state filed a motion to stay enforcement of the May 2000 Remedial Plan pending resolution of proposed modifications. On November 27, 2000, the plaintiffs filed a brief in opposition to the defendants' motion. The defendants filed a Revised Remedial Plan with the court on December 18, 2001, and on January 29, 2001, the Tennessee Justice Center filed a motion with the court requiring the state to show cause why it should not be held in contempt for violating the March 12, 1998, *John B. Consent Decree* and the May 16, 2000, Agreed Order concerning the Remedial Plan.

During the past few months, a great deal of time and effort on the state's part has been spent responding to discovery requests from the plaintiffs, preparing for the hearing which began on June 18, 2001, adding new staff, clarifying staff roles and responsibilities, and re-training staff on program policies and organization. Also during this period, the state carried out the first ballot period for TennCare enrollees in two years, implemented a major reconfiguration of Managed Care Organizations around the state (including assisting two new MCOs in becoming operational), brought up its own MCO (TennCare Select), conducted a series of public forums in all parts of the state on the recommendations of the Governor's Commission on the Future of TennCare, worked with actuaries to complete the second annual actuarial study of the TennCare Program, completed mailings in accordance with the *Rosen* Agreed Order, and completed negotiations for the *Brian A.* Settlement Agreement for DCS children. A new contractor, Schaller-Anderson, was retained to oversee medical appeals for TennCare during the period of this report. Another contractor, Fox Systems, worked with the state to plan a redesign of the TennCare Management Information System.

Infrastructure Improvements

1. Children's Health Initiative

A major infrastructure improvement added during this report period was the implementation of the Children's Health Initiative (CHI). The CHI, headed by Dr. Joe McLaughlin, a child psychologist with extensive experience working in public health programs, was set up to provide assurance that appropriate child health and child mental health services are provided in Tennessee. The unit is located within the Office of Health Services, Department of Finance and Administration.

Specific purposes of the unit include serving as a liaison with all child-serving departments of state government, developing and monitoring interagency agreements for child health and child mental health services, convening regular meetings of the Commissioners of the child-serving departments, resolving interagency problems, and providing oversight of compliance with *John B.* The unit reports directly to John Tighe, Deputy to the Governor for Health Policy, and is already playing a major role in addressing the critical clinical and interdepartmental activities that are such an important part of *John B.*

Two key clinical professionals in the CHI are bringing their expertise to a variety of issues surrounding services to children. These staff persons include Dr. McLaughlin and Dr. Patti van Eys, a clinical psychologist with an advanced certificate in multidisciplinary approaches to child sexual abuse intervention. There is also an EPSDT Compliance Officer, Mary Griffin, who is an attorney with experience in TennCare issues, including multicultural concerns. A data analyst is being recruited for the unit.

All of the child-serving departments have signed an interdepartmental agreement recognizing the authority of the CHI in resolving interagency disputes. (See Attachment A.) It is understood that Dr. McLaughlin and his staff have the "final word" whenever there is a situation affecting children's health or mental health services which cannot be resolved through the usual channels.

2. Brian A. Settlement Agreement

The Department of Children's Services participated in five months of intense negotiations resulting in the *Brian A.* Settlement Agreement in July 2001. The Settlement Agreement will allow DCS to go ahead with reforms already begun in cooperation with the nationally known Child Welfare League of America. Substantial improvements are being put in place regarding foster care and adoption programs.

DCS has announced plans to hire the following new personnel:

- 335 case managers and supervisors,
- 46 persons to staff a centralized intake service to receive reports of child abuse and neglect,
- 10 persons to work as a Child Protective Services Special Assist Team, which will be assigned to large scale investigations of alleged child abuse, and
- 6 administrative personnel.

Overseeing the implementation of the Settlement Agreement is Director of Compliance Kent Berkley, formerly assistant general counsel for DCS, and an independent and neutral monitor, Sheila Agneil, who is from Kansas City and who has performed a similar role in two other states, New Mexico and Missouri. A technical assistance committee has been created to assist in monitoring quality assurance and placement of children in a timely manner.

3. EPSDT Steering Committee

The EPSDT Steering Committee, which was appointed in October 2000 by TennCare Director Mark Reynolds and which continues to be chaired by Commissioner Reynolds, has met on an every-other-week basis for the purpose of analyzing EPSDT issues and discussing new projects. The committee is directly responsible for initiating many of the activities outlined in these pages.

4. TennCare Select

The proposed Revised Remedial Plan submitted to the Court in December 2000 called for a “carve-out” managed care model for children. This “carve-out,” which is called TennCare Select, was developed during this reporting period and implemented on July 1, 2001. TennCare Select was designed to accomplish several purposes, chief among them being creation of a vehicle for providing more smoothly coordinated services to children in DCS state custody and certain other special needs children. The framework for choosing which children would be considered “special needs” children was taken from a “Dear State Medicaid Director” letter issued by the Health Care Financing Administration (now Centers for Medicare & Medicaid Services) in January. (See Attachment B.)

TennCare Select incorporates the Centers of Excellence and Best Practice Networks envisioned by the Remedial Plan and the Revised Remedial Plan. (See page 12 for more information on the Centers of Excellence and the Best Practice Guidelines.)

5. Implementation Team (Remedial Plan)

Under the leadership of Dr. Larry Faust, the Implementation Team established a year ago by the original Remedial Plan has been very active in assisting children whose needs are such that state custody might be required if they are unable to obtain appropriate services. The team advocates for these children to obtain the mental or physical health services that they need. One hundred twelve cases were reviewed during the report period. Eight letters of authorization for services for six children were issued. Letters of authorization assure state payment for services the Implementation Team has found to be immediately necessary for prevention of custody, regardless of whether or not the services are ultimately determined to be "medically necessary" and therefore coverable by the MCOs/BHOs.

6. TennCare/TDMHDD/DCS/BHO work group

Under the leadership of Paul Miller, Director of Operations for the TennCare Partners Program, a workgroup was formed in October 2000 to pro-actively review and resolve problem cases, workflow, and operational issues that are identified as impeding or impacting the efficiency and effectiveness of the TennCare Partners program. The work group meets on the first and third Tuesday of each month.

Although the work group does not focus solely on children's issues, the majority of its attention to date has been directed toward resolving problems in delivery of children's mental health services. Participants have discussed 50-75 children's cases and fewer than 20 adult cases. In the early part of this calendar year, the Implementation Team was added to the group, since some of the cases being discussed by the work group were the same ones being handled by the Implementation Team.

The consensus of the group is that the meetings are productive and helpful in resolving both individual and systemic issues in children's mental health.

7. Review of provider contracts (Paragraphs 102-103)

Two new MCOs joined TennCare during the report period. These MCOs were Better Health Plans of Monroeville, Pennsylvania, and Universal Care of Signal Hill, California. As part of the readiness process, all of these MCOs' provider contract templates and subcontracts were reviewed by the TennCare Division of the Tennessee Department of Commerce and Insurance and by TennCare. Provisions which might encourage non-compliance with EPSDT were specifically pointed out, and revisions were required before the organizations were allowed to begin operations.

8. MCO Contractor Risk Agreement revisions and enforcement

The new MCO CRA, which was effective July 1, 2001, included several major EPSDT changes, such as the addition of incentive payments for improved screening rates. A summary of the changes is presented in Attachment C.

Actions taken by the Office of Contract Development and Compliance with respect to EPSDT during the report period are summarized in Attachment D.

9. Staff improvements at TennCare

Three new key management positions were created at TennCare during this report period. Peter Sybinsky was named Assistant Commissioner for Delivery Systems. Mr. Sybinsky most recently served as Deputy Secretary for Policy and Research for the Family and Social Services Administration for the state of Indiana. At TennCare, Mr. Sybinsky oversees policy and administration of TennCare Select, MCO Programs, Pharmacy Services, Long-Term Care, and TennCare Partners. One of his responsibilities is to coordinate the identification and resolution of systemic EPSDT issues.

Nancy McLean has been appointed Assistant Commissioner of Member Services. Ms. McLean is an attorney with experience in state government. Her responsibilities include oversight of the Medical Appeals unit, the Administrative Appeals unit, the Information Line, the Eligibility unit, and the Member Policy unit.

Matthew Moore has been named Director of MCO Programs. He has a Master's degree in health administration and over six years of specifically related health care and managed care experience. Mr. Moore, who has been successful in developing strong provider/plan relationships including contract negotiations and monitoring, is responsible for monitoring MCO compliance and supervises the TennCare Contract Development and Compliance unit.

The activities which these new senior staff persons are responsible for are integral to the strength of the EPSDT program. The addition of their expertise and knowledge is invaluable to TennCare in achieving its goal of continuous improvement in services to children under EPSDT.

Progress on Outreach and Informing

1. Ballot mailings

All TennCare households received ballots in April 2001 and were asked to return these ballots if they wanted to change MCOs. The result of the ballot period was the largest re-assignment of TennCare enrollees since the beginning of the program. Not only were individuals assigned to new MCOs of their choice, but they also received letters providing them with 90 days to request another change, if they wished. Outreach information about EPSDT was included in the mailings accompanying the ballot materials.

2. Mailings to households with children past due for EPSDT screens (Paragraph 40)

On April 23, 2001, the Bureau of TennCare sent letters to each MCO asking them to identify by name all enrollees who were past due for their EPSDT screens. Replies were received from the MCOs by May 20, 2001. MCOs were asked to develop corrective action plans for helping families get these children up-to-date on screens. These corrective action plans were received by the Quality Oversight unit by July 10, 2001. Responses to the corrective action plans are being finalized.

As a companion to the MCO actions, the Bureau of TennCare sent out its own mailing at the end of June to about 240,000 individual children who were determined to be overdue for screenings. The letters, which were also prepared in Spanish, discussed the importance of well-child screens, the availability of services such as dental screens, and information on how to find services and learn more about EPSDT.

The change period which took effect July 1, 2001, meant that a number of TennCare children were in new MCOs at the start of the state fiscal year. Names of past-due enrollees who were changing MCOs were communicated to the enrollees' new MCOs, and plans were made by the MCOs to complete a mailing about EPSDT screens to families of all of these children by the end of August 2001.

3. Quarterly reports on outreach

MCOs submitted quarterly reports on their outreach activities in January and April of 2001. These reports were sent to the Quality Oversight unit. They are contained in Attachment E.

4. TennCare website

The TennCare website (www.state.tn.us/tenncare) was revised during the report period. An icon labeled "Children's Page" was added with information about EPSDT, including a list of the components of EPSDT screenings, a list of the screening guidelines recommended by the EPSDT Screening Guidelines Committee, information about the periodicity schedule, and the names of MCO EPSDT Coordinators.

5. Public awareness campaign

During the reporting period, a \$150,000 contract with Stagepost was developed. The purpose of the contract was to prepare a public awareness campaign on EPSDT. Planning for the campaign is now underway. It is expected that the campaign will include a number of different activities and events.

Progress on Screening

1. Computation of the Annual Periodic Screening Percentage (Paragraph 49)

The Annual Periodic Screening Percentage (APSP) for FFY 99 was 19.8%. The target for FFY 00 was a 20-point improvement.

The actual APSP for FFY 00 was 31.5%. This figure was obtained by multiplying the HCFA 416 screening percentage for FFY 00, which was 45%, by the results of the annual medical record review, which indicated that 69.9% of the required seven components were contained in the medical records of a statistically valid sample of children receiving screens. The Adjusted Periodic Screening Percentage (APSP) of 31.5% represented an increase of nearly 10 percentage points over the baseline APSP in FFY 96.

The dental screening percentage (DSP) for FY 00 was 33%. This represented an increase of nearly five percentage points over the baseline DSP in FFY 96.

Thus, in FFY 00 nearly half the children in the TennCare program received documented screens when they were supposed to, and these screens contained, on average, 70% of the required seven components. One in three TennCare children received a documented dental screen during FFY 00.

The state is involved in a number of continuous improvement activities, many of which are mentioned in this report, to improve these rates in the coming months. We will continue to try new approaches in order to improve the screening rates and accuracy.

2. DCS screening activities (Paragraph 52)

The Department of Children's Services made significant progress in its attempt to assure appropriate screenings of the children it serves. On April 1, 2001, a new set of EPSDT standards was published, superseding previous standards. (See Attachment F.) These standards set out procedures for obtaining EPSDT screenings, information about what the screenings should include, and policies on incorporating the results of the EPSDT screening into the child's Permanency Plan.

DCS reported that as of April 1, 2001, 91.3% of its children had received EPSDT screenings within the past year. The percent of children over aged 3 who had received dental screenings within the past year was 81.7%.

3. Public health screening enhancements (Paragraph 43)

During this report period plans were made to enhance the capability of local health departments to perform EPSDT screens. A total of \$4.4 million was made available to the Bureau of Health Services Administration for contracts with metropolitan and rural health departments across the state. These contracts are currently being finalized.

4. EPSDT documentation pilot (Paragraph 44)

The most recent medical record review indicated that about 70% of the required seven components are documented in the records of a sample of children receiving EPSDT screens. The question has been raised as to whether or not documentation would improve if EPSDT screening providers received an incentive payment for filling out an EPSDT "attestation form" indicating which screens were done. The Bureau of TennCare asked Blue Cross/Blue Shield to conduct a pilot study to respond to this question.

Nine practitioners were chosen to participate in the first phase of the study by filling out an "attestation form" when they performed EPSDT screens. In the 147 attestation forms received, 87% of the required seven components were documented as delivered, with vision and hearing appearing to be the areas with the lowest rates. A chart review revealed 95% accuracy when comparing the attestation forms to the documentation in the chart. Claims for all the visits were filed as preventive health claims. Study results will be reviewed by the EPSDT Steering Committee at TennCare to determine next steps. (See Attachment G.)

The second phase of the study is nearly complete. This is an expanded study which includes practices chosen due to higher volume of TennCare enrollees. The analysis will seek to measure whether or not use of the attestation form improves screening numbers and completeness. These results should be available shortly.

5. Web-based training for providers (Paragraph 44)

Plans were made during this report period for the development of a web-based educational service on EPSDT for primary care providers in TennCare. A contract in the amount of \$133,900 was completed with CyberCE, Inc. The contract will provide on-line interactive training on EPSDT for PCPs. Training sessions will be recorded in a multi-media format which will be archived for access by additional PCPs. Some sessions will cover EPSDT screening in general, and others will focus on specific EPSDT-related topics. Sessions are planned on hearing and vision screening and on developmental and behavioral screening. The first general sessions are expected to be conducted in September 2001.

6. TennCare video (Paragraph 44)

Dr. Joe McLaughlin developed a 16-minute video for primary care providers describing the elements of an EPSDT screening visit. Reviews of the video script and/or the initial version of the videotape were provided by several TennCare staff including the interim Medical Director and staff of the Children's Health Initiative; pediatricians from the Tennessee Chapter of the American Academy of Pediatrics; and representatives of several advocacy groups including the Tennessee Health Care Campaign, Tennessee Voices for Children, and Family Voices. As of the end of June, the initial version of the video was complete except for minor revisions. When finalized, the video will be distributed to all primary care providers who see children under TennCare. It will be accompanied by print materials giving PCPs additional information about procedures for EPSDT screening visits. The video includes details of recommendations from the EPSDT Screening Guidelines Committee.

7. Training on new screening guidelines (Paragraph 44)

A "train the trainer" conference was held in January 2001 for MCO personnel. The purpose of the conference was to expand the numbers of persons who were familiar with the EPSDT Screening Guidelines and who could train others on their use. Sixty-two persons representing all MCOs, BHOs, and dental plans participated in the conference. Dr. Frances Glascoe, a nationally recognized trainer and child development expert, gave the major address.

8. TSOP on interperiodic screening (Paragraph 42)

On February 23, 2001, TennCare published TennCare Standard Operating Procedure (TSOP) 036, Addendum 4, on interperiodic screenings. This TSOP was distributed to TennCare's contractors and posted along with the other TSOPs on the TennCare website (www.state.tn.us/tenncare).

Progress on Diagnosis and Treatment Activities

1. Dental carveout

Recognizing that access to dental services for TennCare children, like access to dental services for Medicaid children in other states, is sometimes difficult, the state began planning during this report period for a dental carveout to be implemented in January 2002.

A Children's Oral Health Planning Group, chaired by Dr. Joe McLaughlin, was established to plan for improvements in dental services for TennCare children. The group includes the State Dental Director from the Department of Health, TennCare staff, a representative of the Governor's office, private practice dentists, representatives of the Tennessee Dental Association, faculty from the UT School of Dentistry, the Dental Director of the Matthew Walker Health Center in Nashville, and representatives of some advocacy groups. Several members of the group attended a National Governors Association Policy Academy on Children's Oral Health held in Nashville May 7-9, 2001. They are now meeting to follow up on the planning conducted at the conference.

2. Public health dental improvements

Plans were made to develop a school-based dental screening, sealant, referral and outreach program through the Bureau of Health Services. The \$7 million program is adding 100 new public health dental hygienists and public health dentists across the state. The target public schools for the program are those in which 50% or more of the student population is eligible for the free lunch program. All students will receive a dental screen. Students with signed permission slips will receive dental sealants as clinically indicated. In addition, students who have signed permission slips and are enrolled in the TennCare program will receive an oral evaluation. Information will be sent home to parents regarding any identified need for treatment or further evaluation. Follow-up will be provided to all children with urgent dental needs. Health department staff will be available to assist parents in accessing services following the school-based program. Finally, outreach will be conducted with the families of children who are enrolled in the free lunch program but who are not enrolled in TennCare.

Currently clinical dental services are offered through 36 rural and three metropolitan health departments. Capital improvements are planned for health departments in 22 counties in order to expand or create the ability for those health departments to deliver clinical dental services to children. The total project budget is expected to be \$2 million. Additional resources have been committed to order two mobile dental vans for the Mid Cumberland and Northeast Regions to provide another model for delivering dental services in rural areas.

Following the completion of the construction and remodeling associated with the infrastructure grants and improvement in the TennCare dental fees, clinical dental services will be available through 49 rural and four metropolitan health departments.

3. Centers of Excellence

During the report period Dr. Joe McLaughlin held several discussions with representatives of the five major pediatric medical centers across the state to develop the Centers of Excellence role in the Revised Remedial Plan. As of June 30, 2001, proposals were in hand from three of the five centers (Vanderbilt, UT Memphis, and ETSU), with the other two (Erlanger and UT-Knoxville) expected shortly.

4. Best Practice Guidelines

Drafts of Best Practice Guidelines have been completed and are currently being reviewed. Dr. Larry Faust of the Department of Health and Dr. David Moroney of Blue Cross/Blue Shield coordinated the development of the BPGs for medical services, and Dr. Judy Regan of TDMHDD and Dr. Patti von Eys of the Children's Health Initiative coordinated the development of the BPGs for mental health services. (See Attachments H and I.)

Progress on Monitoring

1. Semiannual review of appeals (Paragraph 101)

The semiannual review of appeals required in Paragraph 101 was completed and is included in Attachment J.

In March 2001, TennCare named Andrea Thaler as Director of the TennCare Solutions Unit. Ms. Thaler has had a wealth of experience in health care delivery, most recently as an executive with Access MedPlus. In July 2001, TennCare appointed Nancy McLean to the new position of Assistant Commissioner for Member Services, which will include oversight of the TennCare Solutions Unit. (See page 5.)

2. Proposed study of children in custody (Paragraph 73)

The EPSDT Steering Committee proposed a second study to respond to the concerns of Paragraph 73. The contractor for the new study is the Center for Child Mental Health Services at the University of Tennessee in Knoxville. TennCare staff have worked with the UT staff to develop the study design; staff from the center have met with the plaintiffs' attorneys to review the study design. The amount of the contract is \$506,000.

This will be a two-part study that will include a sample of children in East Tennessee and another sample in Shelby County (contingent on reaching an agreement with juvenile court personnel in Shelby County). It will begin on August 1, 2001. It will involve a series of assessments of children and families who come to the attention of the juvenile court, as well as interviews with key persons, including juvenile court personnel. The study will determine the nature of behavioral services received by the children and will examine the risk factors that led to, or prevented, state custody. The combined samples for the two studies are expected to total 1200 children.

The sample will be chosen from a list of all children who came into custody as of a certain date and who had had continuous TennCare coverage for at least six months prior to entering custody. Researchers will interview DCS caseworkers, the child's PCP, the child's primary mental health caregiver if appropriate, a representative of the child's current placement (foster parent, group home, etc.), the child's parent(s) if appropriate, and the child's teacher at school if appropriate. They will review the child's medical records and DCS records, encounter data from the child's MCO/BHO, prior approval files from the MCO/BHO to determine if services were requested but denied, and TennCare appeal files. They will also perform a clinical assessment of each child to determine how well he/she is functioning currently.

Information from the above sources will be analyzed to identify the major factors contributing to the child's entry into custody and to determine whether or not the entry into custody could have been prevented if the child had received different services from TennCare. An analysis will also be done of how well the child is doing now, given the services he has received from TennCare and DCS. At the conclusion of the study, the data will be aggregated and recommendations developed for TennCare and DCS.

3. New contract for assistance with medical appeals (Paragraph 101)

During the period of this report, the Bureau of TennCare entered into a contract with Schaller Anderson, a health care management and consulting firm specializing in Medicaid managed care. The purpose of the contract is to assist the Bureau in developing medical policy and clinical criteria for use by the Bureau and the managed care contractors, to assist the Bureau in applying newly developed policies and procedures to the appeals process, and to assist the TennCare Solutions Unit with *Grier* implementation. A significant element of these tasks is the development and implementation of a new information system for documentation and tracking of appeals. The total amount of the contract over a three-year period is \$12.8 million.

Schaller Anderson has already begun reviewing existing TennCare appeals data and developing recommendations. As an example, pharmacy appeals are the most numerous appeals, making up about 40% of the volume of all TennCare appeals. Pharmacy appeals for all enrollees, adults as well as children, have increased substantially in recent years, quadrupling from 1999 to 2000 and, as of July 2001, already surpassing the complete year 2000 totals. Schaller Anderson has identified four leading classes of drugs generating appeals--pain medications, respiratory medications, antibiotics, and anti-ulcer medications. All data collected by Schaller Anderson in the future will be grouped into adult and child categories for ease of analysis of EPSDT systemic problems.

After identifying service and appeals issues, Shaller Anderson will assist the Bureau by working with Managed Care Contractors and providers to bring about improvements in utilization review decisions and practice patterns.

4. Contract with the Tennessee Chapter of the American Academy of Pediatrics

A contract in the amount of \$67,800 was developed with TCAAP to assist in several projects to improve the quality of EPSDT services. TCAAP pediatricians have reviewed the EPSDT screening video for primary care providers, reviewed plans for the web-based educational program, and conducted two sessions in Middle Tennessee with pediatricians regarding EPSDT and the medical home

concept. The pediatricians are providing their expertise on a volunteer basis; the funds in the contract are earmarked for staff support and incidental expenses.

5. Provision of updated lists of specialists to PCPs (Paragraph 62)

The Office of Contract Development and Compliance at TennCare monitored the MCOs' provision of updated lists of specialists to PCPs on a quarterly basis.

6. Provision of mental health case management services to children leaving psychiatric hospitals and residential treatment facilities (Paragraph 71)

The Quality Oversight unit continued to monitor the provision of mental health case management services to children leaving psychiatric hospitals and residential treatment facilities. A sample of records is reviewed each month. As of February 2001, 97.68% of all children identified as Severely Emotionally Disturbed (SED) or Seriously and/or Persistently Mentally Ill (SPMI) who were discharged from psychiatric hospitals and psychiatric residential treatment facilities were offered a referral for mental health case management within the required timeframes; 87.5% received a face-to-face case management encounter within the required timeframes.

Progress on Coordination of Effort

1. Commissioners' meetings (Paragraph 83)

A monthly interdepartmental meeting of Commissioners and/or their designees has been instituted. The committee met in June and again in July, and included representatives from Health, TDMHDD, DCS, Education, DHS, the Division of Mental Retardation, and TennCare. To date, the group has used a case review format to highlight issues where interdepartmental coordination is needed.

2. Statewide list of services (Paragraph 79)

The Bureau of TennCare updated its statewide list of services which was sent to contractors in 1998. The new list was sent out on February 28, 2001.

3. Collaboration with other agencies (Paragraph 78)

During the report period, Dr. Faust participated in several regional Juvenile and Family Court Judges Help 4 Kids programs designed to identify barriers and solutions with respect to children's access to care. He also worked with Family Voices for Children in obtaining a CATCH (Community Access to Children's Health) grant through the American Academy of Pediatrics. This grant will provide support for a medical home planning project in Tennessee.

Dr. Joe McLaughlin worked with a number of state agencies, professional organizations, and advocacy groups to assist in a conference on June 15, 2001, entitled "From TennCare Policy to Programs: What is Working in Tennessee?" The conference was organized by Debi Tate of the Vanderbilt Institute for Public Policy Studies, Jennifer Carlat of the TennCare for Children Program, and Amy Hoskins of the Early Child Health Outreach Program. The meeting was well attended and provided many examples of good clinical and administrative practices for serving TennCare children. Follow-up of the meeting is to include on-line discussion groups to continue to work on outreach and education to parents regarding EPSDT, integration of health and mental health services, outreach to non-English speaking populations, and increasing health and mental health services in school settings.

One of the items produced for the conference by Dr. McLaughlin was a brief video illustrating the importance of TennCare in providing services for several special needs children.

Another activity of Dr. McLaughlin during the report period was presentation of information on the EPSDT Screening Guidelines Committee recommendations

and information on the Children's Health Initiative to the leadership meeting of the Tennessee Chapter of the American Academy of Pediatrics on May 5, 2001. The presentation was followed by detailed discussion with TCAAP leadership regarding collaboration with state agencies to improve EPSDT services.

Dr. McLaughlin is also chairing the newly established TennCare and Children Workgroup, which consists of representatives of advocacy groups, the TennCare Bureau, and other state agencies who come together for the purpose of collaborating on the identification and resolution of systemic problems in the provision of EPSDT services.

4. EPSDT Coordinators' meetings

Two EPSDT Coordinators' meetings were held during the report period. These meetings focused primarily on outreach and increasing screening visits.

Attachment A

Interagency Agreement

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- C Summary of EPSDT Changes in New MCO CRA
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INTERAGENCY AGREEMENT

AMONG

THE STATE OF TENNESSEE,

DEPARTMENT OF FINANCE AND ADMINISTRATION, BUREAU OF TENNCARE,

DEPARTMENT OF HEALTH, BUREAU OF HEALTH SERVICES ADMINISTRATION, DEPARTMENT OF CHILDREN'S SERVICES, DEPARTMENT OF FINANCE AND ADMINISTRATION, DIVISION OF MENTAL RETARDATION SERVICES, DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

AND

DEPARTMENT OF FINANCE AND ADMINISTRATION, OFFICE OF HEALTH SERVICES, CHILDREN'S HEALTH INITIATIVE

This Agreement, by and between the state of Tennessee, Department of Finance and Administration, Bureau of TennCare (hereinafter referred to as "TennCare"), the Department of Health, Bureau of Health Services Administration (hereinafter referred to as "HSA"), the Department of Children's Services [hereinafter referred to as "DCS"], the Division of Mental Retardation Services [hereinafter referred to as "DMRS"], the Department of Mental Health and Developmental Disabilities [hereinafter referred to as "DMHDD"] and the Department of Finance and Administration, Office of Health Services, Children's Health Initiative [hereinafter referred to as "CHI"] is for the provision for the establishment of a dispute resolution process for CHI in unresolved cases of an interagency nature relating to health care services for children and to provide oversight of compliance with *John B. v. Menke*, No.3-98-0168 (M.D. Tenn., March 11, 1998).

WHEREAS, TennCare is the single State agency for the administration of medical assistance services, including the TennCare Program and long term care services, in the state of Tennessee, in accordance with Title XIX of the Social Security Act, which is managed through TennCare, as provided at T.C.A. §71-5-104; and

WHEREAS, TennCare, HSA, DCS, DMRS and DMHDD agree that this InterAgency Agreement does not constitute any delegation of their respective statutorily-derived policy and decision making authority; and

WHEREAS, All Parties agree that this Interagency Agreement does not constitute any delegation by TennCare of Medicaid policy and decision making authority; and

WHEREAS, HSA is the State Title V agency; and

WHEREAS, HSA directly, or through contractual arrangements, provides public health services through local health departments in all 95 counties in Tennessee; and

WHEREAS, DCS is the State agency which provides services for children in or at risk of state custody so that these children can reach their full potential as productive, competent and healthy adults. DCS provides services to those children who are unruly, delinquent, dependent and neglected, or as otherwise required by State law; and

WHEREAS, DCS is the single State agency for the administration of the Title IV-B Child Welfare Services Program (42 U.S.C. 620) and the Title IV-E Foster Care and Adoption Assistance Program (42 U.S.C. 670) established pursuant to the Social Security Act, or any successor entitlements, through the DCS Division of Child & Family Management, as provided at T.C.A §37-5-106(12); and

WHEREAS, DMRS is the lead Agency for the administration of the Home and Community Based Waivers for persons with mental retardation. DMRS provides support and services to persons with mental retardation and their families.

WHEREAS, DMHDD is the State Agency responsible for administering and overseeing the mental health and substance abuse components of the TennCare program.

WHEREAS, the Governor has established an Office of Health Services to coordinate health services among agencies; and

WHEREAS, a special unit called the Children's Health Initiative (CHI) has been established within the Office of Health Services to coordinate and facilitate "health services to children", which as it pertains to this agreement, shall include medical, mental health, dental, mental retardation/developmental disabilities services and substance abuse services. The term "child" or "children" shall refer to a person under the age of 21; and

WHEREAS, CHI acts as a liaison with TennCare, HSA, DCS, DMRS and DMHDD, to develop and to monitor Interagency Agreements and Memorandums of Understanding for child health and child mental health services, to resolve issues and interagency disputes, to develop and to facilitate coordination and communication among the agencies, and to provide oversight of compliance with *John B. v. Menke*; and

WHEREAS, TennCare, HSA, DCS, DMRS, DMHDD and CHI have a common interest in fulfilling the requirements of Paragraph eighty three of the Consent Decree for Medicaid-Based Early and Periodic Screening, Diagnosis and Treatment Services, hereinafter referred to as "EPSDT", entered by the Court in the matter of *John B. v. Menke*, specifically the requirement for dispute resolution; and

WHEREAS, TennCare, HSA, DCS, DMRS, DMHDD and CHI have a common interest in assuring that their eligible enrollees and clients gain access to health services to children; and

WHEREAS, TennCare, HSA, DCS, DMRS, DMHDD and CHI have a common interest in assuring compliance with EPSDT, 42 CFR Section 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989; and

WHEREAS, TennCare, HSA, DCS, DMRS, DMHDD and CHI mutually recognize the desirability of assisting eligible children served by the Contractor in accessing health services to children; and

WHEREAS, TennCare, HSA, DCS, DMRS, DMHDD and CHI mutually recognize that coordination between them will serve the best interest of the State.

NOW, THEREFORE, in consideration of the mutual promises contained herein, the parties do hereby enter into this Agreement according to the provisions set forth herein.

A. SCOPE OF SERVICES

- A.1. TennCare, DCS, HSA, DMRS, and DMHDD agree to the dispute resolution, monitoring and tracking processes provided herein.
- A.2. CHI agrees that the following are its responsibilities and obligations under this agreement:
 - A.2.a. Development of policy relating to health services to children.
 - A.2.b. Act as liaison between the parties to this agreement.
 - A.2.c. Develop and monitor Interagency Agreements and Memorandums of Understanding.

A.2.d. Act as a final Arbiter to resolve issues and interagency disputes involving health services to children.

A.2.e. Facilitate coordination and communication among the parties to this agreement.

A.2.f. Provide oversight for compliance with *John B. v. Menke*.

B. REVIEW PROVISION

B.1. Parties to this Agreement shall meet on a regularly scheduled basis at the Commissioners' EPSDT Meeting to review the performance of the activities under this Agreement.

B.2. Technical assistance and consultation may be requested of CHI as needed by the parties to this agreement.

C. DISPUTE RESOLUTION

C.1. When there is a dispute among the agencies named herein relating to the provision of health services to children, there will be a referral to CHI for resolution of any dispute which is otherwise not resolvable between the parties.

C.2. When an interagency dispute is not otherwise resolvable, CHI shall issue a Mandate to TennCare, HSA, DCS, DMRS or DMHDD requiring specific action.

C.3. If the Mandate is not complied with, a Finding of Non Compliance shall be conveyed through the Deputy to the Governor for Health Policy to the Governor.

D. MONITORING AND TRACKING

D.1. Monitoring. For purposes of monitoring under the Agreement, TennCare, HSA, DCS, DMRS and DMHDD shall cooperate and make available to CHI all information relating to obligations under this Agreement.

D.2. Tracking. CHI shall track deadlines and obligations of the parties to this agreement in an effort to assure compliance under *John B.* This agreement does not abrogate or diminish the duties and obligations of the contracting parties and their staff.

E. AGREEMENT TERM

E.1. Agreement Term. This Agreement shall be effective for the period commencing on August 1, 2001, and ending on July 31, 2006. It is expressly understood and agreed that the obligations set forth in this section shall survive the termination of this Agreement and/or departmental reorganization.

F. SPECIAL TERMS AND CONDITIONS

F.1. Communications and Contracts. All instructions, notices, consents, demands, or other communications required or contemplated by this Agreement shall be in writing and shall be made by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below or to such other party, facsimile number, or address or may be hereafter specified by written notice.

TennCare: Coordinator: Susie Baird
729 Church Street
Nashville, TN 37243
Facsimile: (615) 741-0882

DCS: Coordinator: MaryBeth Franklyn
436 6th Avenue North
7th Floor, Cordell Hull Building
Nashville, TN 37243
Facsimile: (615) 532-3586

HSA: Coordinator: Dr. Wendy Long
Cordell Hull Building, Fourth Floor North
425 5th Avenue North
Nashville, Tennessee 37247
Facsimile: (615) 532-2286

DMRS: Coordinator: Kathy Dungan
Cordell Hull Building, Fifth Floor North
425 5th Avenue North
Nashville, Tennessee 37243
Facsimile: (615) 532-9940

DMHDD: Coordinator: Sherry Harrison
Cordell Hull Building, 3rd Floor
425 5th Avenue North
Nashville, Tennessee 37243
Facsimile: (615) 253-3187

CHI: Coordinator: Dr. F. Joseph McLaughlin
706 Church Street
5th Floor, Doctor's Building
Nashville, Tennessee 37243
Facsimile: (615) 532-1383

The Coordinators are designated for issues arising in the daily implementation of this Interagency Agreement. Such designation may be changed during the period of this Agreement only by written notice. The designated Coordinator shall be authorized to represent his/her agency/entity with respect to all matters relating to the implementation of this Agreement. The Coordinator shall not be empowered to amend this Agreement.

Instructions, notices, consents, demands, or other communications shall be considered effectively provided as of the day of delivery; as of the date specified for overnight courier service delivery; as of three (3) business days after the date of mailing; or on the day that the facsimile transmission is received mechanically by the telefax machine at the receiving location and receipt is confirmed telephonically by the sender if prior to 4:30 p.m. CST. Any communication by facsimile transmission shall also be sent by messenger service or United States mail on the same date of the facsimile transmission.

- F.2. Modification and Amendment. This agreement may be modified only by a written amendment executed by all parties hereto.
- F.3. Confidentiality of Records. Strict standards of confidentiality of records including, but not limited to, patient medical records and other similar records shall be maintained in accordance with the state and Federal law, including Federal confidentiality standards found at 42 CFR 431.300-307. All materials and information provided to or by the parties to this Agreement, whether oral, written, magnetic tape, cards, or otherwise, shall be regarded as

confidential information in accordance applicable law and ethical standards. Such confidential information shall not be disclosed, and all necessary steps shall be taken by the parties to safeguard the confidentiality of such materials or information in conformance with applicable law and ethical standards.

The parties will be deemed to have satisfied their obligations under this section by exercising the same level of care to preserve the confidentiality of information as they exercise to protect their own confidential information so long as such standard of care does not violate the applicable provisions of the first paragraph of this section.

The parties' obligations under this section do not apply to the following: information in the public domain; information entering the public domain, but not due to a breach by the applicable party; information previously possessed by the applicable party without written obligations from the other party to protect it; information acquired by the party without written restrictions against disclosure from a third party which, to the party's knowledge, is free to disclose the information; information independently developed by the party without the use of the other party's information; or, information disclosed by the party to others without restriction against disclosure.

IN WITNESS WHEREOF, the parties have by their duly authorized representative set forth their signatures.

DEPARTMENT OF CHILDREN'S SERVICES

7/27/01
Date

George W. Hattaway
George W. Hattaway, Commissioner

DEPARTMENT OF MENTAL HEALTH
AND DEVELOPMENTAL DISABILITIES

7/27/01
Date

Elisabeth Rukeyser
Elisabeth Rukeyser, Commissioner

DEPARTMENT OF HEALTH

7/27/01
Date

Fredia S. Wadley
Fredia S. Wadley, M.D., Commissioner

DEPARTMENT OF FINANCE AND ADMINISTRATION

7/27/01
Date

C. Warren Neel
C. Warren Neel, Ph.D.

BUREAU OF TENNCARE

7/27/01
Date

Mark E. Reynolds
Mark E. Reynolds, Deputy Commissioner

DIVISION OF MENTAL RETARDATION

7/27/01
Date

Barbara Brent
Barbara Brent, Deputy Commissioner

OFFICE OF HEALTH SERVICES

7/27/01
Date

John Tighe
John Tighe, Deputy Commissioner

Attachment B

“Dear State Medicaid Director” Letter



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration
Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850
SMDL #01-012

January 19, 2001

Dear State Medicaid Director:

This letter encloses revised Federal review criteria for children with special health care needs (CSHCN) who are mandatorily enrolled in Medicaid managed care programs. The goal of the revised review criteria is to provide the necessary assurances that CSHCN benefit from appropriate safeguards in Medicaid waiver and demonstration programs. These revised criteria build upon the "Draft Interim Review Criteria (DIRC) for Special Needs Children" that was released on June 4, 1999.

Section 1915(b)(1) of the Social Security Act requires that programs that waive freedom-of-choice of provider must "not substantially impair access to services of adequate quality when medically necessary." These revised criteria represent HCFA's articulation of the safeguards necessary to ensure that access to needed services is not impaired for this vulnerable population within a mandatory managed care environment. As such, these revised criteria – as with the DIRC – will apply to:

- Existing section 1915(b) waiver programs upon next renewal;
- Existing section 1915(b) waiver programs upon modifications that mandatorily move beneficiaries that were in fee-for-service Medicaid into capitated MCOs;
- New section 1915(b) waiver program or new section 1115 demonstrations;
- Section 1115 demonstrations upon the end of a 3-year extension period authorized by section 4757 of the Balanced Budget Act of 1997; and
- Section 1115 demonstrations otherwise extended ("non-section 4757").

In all these instances, the criteria apply to managed care programs in which Medicaid beneficiaries are *mandatorily enrolled* (or default-enrolled) into capitated Managed Care Organizations (MCOs)/Prepaid Health Plans (PHPs). In States operating mixed-model MCO/PHP and Primary Care Case Management programs, the revised criteria must be addressed for the MCO/PHP component only.

Upon the release of the DIRC, we informed States and other stakeholders that the revised document would be informed by the results of a series of case studies conducted by the National Academy of State Health Policy, our experience working with States using the draft document, and comments from interested parties. That work has now been completed; thus the attached revised document reflects the input of States, advocates, providers, and MCOs. The revised document is also consistent with the requirements addressing populations with special health care needs in the quality provisions (subpart D) of the Final Medicaid Managed Care Rule, released pursuant to the Balanced Budget Act of 1997. The Final Medicaid Managed Care Rule outlines the State's responsibilities for

Page 2 - State Medicaid Director

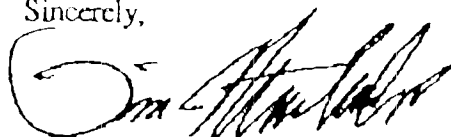
its overall quality strategy for all managed care enrollees and the State's responsibility to address the quality and appropriateness of care delivered to enrollees with special health care needs.

We will soon be working to incorporate this revised document into a new addendum to Section F of the section 1915(b) Waiver Pre-Print, replacing the addendum that currently incorporates the DIRC. Use of the Pre-Print itself remains optional; however, each item in the addendum must be fully addressed in order to obtain HCFA approval to mandatorily enroll beneficiaries into MCOs/PHPs under the circumstances described above.

Throughout this process, HCFA has learned a great deal about State efforts already in place to ensure that CSHCN receive the Medicaid services to which they are entitled. We look forward to these revised criteria further demonstrating States' and HCFA's commitment to this population.

Thank you for your past efforts in applying the DIRC and for your attention to the revised criteria. If you or your staff have any comments or questions, please contact Clarke Cagey of my staff on (410) 786-7700 or ccagey@hcfa.gov.

Sincerely,



Timothy M. Westmoreland
Director

Enclosure

cc:

HCFA Regional Administrators

HCFA Associate Regional Administrators
For Medicaid and State Operations

Lee Partridge
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors' Association

**Review Criteria for Certain Children with Special Health Care Needs
in Mandatory Capitated Managed Care Programs
December 2000**

When addressing these criteria, States should ensure that each of the following are addressed, as appropriate: the State's responsibilities in managed care programs enrolling children with special health care needs; the State's requirements for MCOs/PHPs enrolling children with special health care needs; and how the State monitors its own actions and that of its contracting MCOs and PHPs. Please also note additional resources that may be helpful to States, which are included as endnotes to this document.

Public Process

- The State has in place a public process for the involvement of relevant parties (e.g., advocates, providers, families, caregivers, consumer groups, State agencies, MCOs/PHPs) that treat or otherwise serve children with special health care needs. The State seeks the participation of these parties during the development and ongoing operation of the managed care program.
- The State assures that MCOs/PHPs have a process to seek input from these same groups on relevant operational and monitoring issues on a regular basis.

Definition of Children with Special Health Care Needs

- Using health status/functioning or a categorical basis, the State has developed a definition or definitions of children with special health care needs. At a minimum, the State's definition must include the following five subsets (inasmuch as such groups are enrolled in a mandatory capitated managed care program).¹

Medicaid-eligible children under age 19 who are:

1. Blind/Disabled Children and Related Populations (eligible for SSI under title XVI);
2. Eligible under section 1902(e)(3) of the Social Security Act;²
3. In foster care or other out-of-home placement;
4. Receiving foster care or adoption assistance;
5. Receiving services through a family-centered, community-based coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, as defined by the State in terms of either program participant or special health care needs.³

Identification and Enrollment

- To ensure that the safeguards in this document are applied, the State identifies and/or requires MCOs/PHPs to identify children with special health care needs once they are enrolled in an MCO/PHP. The State indicates which entity is to determine if a child is identified as having a special health care need.⁴
- For foster-care children only, the State describes the enrollment provisions that address the broader, unique issues occurring because of out-of-home, out-of-geographic area placement.
- The State explains the processes it has for identifying any child in one of the five groups described in the Definition section, including: relevant information on screening tools; linkages with other State agencies (e.g., Child Protective Services and Title V); Medicaid claims data, new member outreach; and client surveys.
- The State performs outreach activities that are targeted specifically to reach children with special health care needs and their families, caregivers, providers, and other interested parties regarding the managed care program.
- The State ensures that enrollment counselors have information and training to assist children with special health care needs in selecting appropriate MCOs/PHPs and providers based on their medical needs, including information on how to access up-to-date provider listings. The State articulates the processes it has in place to facilitate interaction between families and enrollment selection counselors.
- Auto-assignment processes assign children with special health care needs to an MCO/PHP that includes their current primary care provider and/or specialists or to an MCO/PHP that is capable of providing a medical home.⁵
- A child with special health care needs can disenroll into fee-for-service or transfer enrollment into another MCO/PHP for good cause or without cause. The State describes the process for disenrollment or transfer under these circumstances. The State ensures that such disenrollment information is appropriately factored into its quality assurance efforts.
- If an MCO/PHP requests to disenroll or transfer enrollment of an enrollee to another plan, the reasons for reassignment are not discriminatory in any way — including adverse change in an enrollee's health status and non-compliant behavior of individuals with mental health and substance abuse diagnoses — against the enrollee. The State describes the corrective action that would take place in instances of any discrimination.
- The State has processes in place for children with special health care needs who have lost and then regained Medicaid eligibility to re-enroll, if desired, with their most recent MCO/PHP.

Provider and Specialist Capacity

- The State consults with its Title V agency to determine how "experienced provider" will be interpreted.
- The State ensures that the MCOs/PHPs in a geographic area have sufficient experienced providers with the ability to meet the unique needs of children with special health care needs (e.g., primary care, specialists, ancillary therapists, hospitals, and mental health providers).
- The State describes how it monitors access to experienced providers, including those who provide specialty care to children.
- The State requires particular specialist types to be included in the MCO/PHP network, taking into account the necessity of including pediatric subspecialties to provide care for children with special health care needs. If necessary primary or specialty care cannot be provided within the network, arrangements are made for enrollees to access these providers (for Medicaid services covered by the contract).
- The State has provisions in MCOs'/PHPs' contracts that allow children with special needs who use specialists frequently for their health care to be allowed to maintain these types of specialists as PCPs or be allowed direct access /standing referral to specialists for the needed care.⁶
- The State describes how it monitors to ensure access to specialty medical equipment and supplies that may be required by children with special health care needs. The State describes how it resolves situations in which there are disputes regarding supplies and equipment.

Coordination

- The State requires a timely and comprehensive assessment of each child's health care needs and implementation of a treatment plan based on that assessment, for any of the five subsets of children described above. The State describes the process for ensuring that children receive these assessments, which include face-to-face physical examinations of children with special health care needs by MCO/PHP providers.
- The State provides or requires the MCOs/PHPs to provide case management or care coordination services to children with special health care needs. The State identifies what entity is held accountable for providing these services.
- The State has a process for coordination with other systems of care that receive Federal funding (for example, Medicare, HRSA Title V grants, Ryan White CARE Act, SAMHSA Mental Health and Substance Abuse Block Grant Funds) and other State and local funding sources (state education agency, child welfare/other social services, Part C lead agency).
- The State requires the MCOs/PHPs to coordinate health care services for children with special

health care needs with the services of other agencies (e.g., mental health and substance abuse, public health department, transportation, home and community based care, developmental disabilities, Title V, local schools, IDEA programs, and child welfare), and with families, caregivers, and advocates.

Quality of Care

- The State has specific performance measures for children with special health care needs (for example, Consumer Assessment of Health Plans [CAHPS] for children with special health care needs; Health Employer Data Information Set [HEDIS] measures stratified by children with special health care needs, etc.).⁷
- The State has specific performance improvement projects that address issues for children with special health care needs.

Other Policy Guidance

- To the extent appropriate, the State has adequately addressed any policy guidance that HCFA has issued to date relevant to children with special health care needs.

Payment Methodology

- The State develops a payment methodology that accounts for children with special health care needs enrolled in capitated managed care.
- The State provides information on any future plans it may have to institute additional risk adjustment for children with special health care needs, including intentions to work with other appropriate State agencies to develop such risk adjustment methodologies.

Plan Monitoring

- The State has in place a process for monitoring children with special health care needs enrolled in MCOs/PHPs for access to services (including EPSDT and also "day-to-day" services such as wheelchairs, in-home therapy, and other supplies), quality of care, coordination of care, and enrollee satisfaction.
- The State has standards or efforts in place regarding MCOs'/PHPs' compliance with ADA access requirements for enrollees with physical disabilities.
- The State's MCO/PHP contracts specify what constitute medically necessary services for children with special health care needs, and it makes these specifications available to families and advocates. The State's specifications address the extent to which the MCO/PHP is responsible for covering services related to a child's ability to achieve age-appropriate growth

and development. Also, the specifications allow approval/authorization of services in a timely fashion.

- The State monitors MCOs/PHPs service authorization policies to ensure that the criteria are consistent with the medical necessity contract specifications and any practice guidelines adopted by the MCO/PHP that are relevant to children with special health care needs.

ENDNOTES (REFERENCES AND RESOURCES FOR REVIEW CRITERIA)

¹ In the Balanced Budget Act of 1997 (BBA), Congress identified these five groups of children as ones to be excluded from mandatory enrollment in managed care under the BBA's state plan amendment process, although it continued to permit their enrollment through waiver or demonstration authority. States should be aware that the BBA "definition" does not include all children who may have a special health care need. In developing a definition, States should consult with appropriate stakeholders, and may want to consider the following definition, which has been endorsed by the Health Resources and Services Administration, DHHS, the American Academy of Pediatrics, and the Association of Maternal & Child Health Programs:

"Children with special health care needs are those who have a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."

² Children who are eligible for Medicaid under 1902 (c)(3) are an optional Medicaid eligibility group (also known as "Katie Beckett" children) who require a level of care provided in institutions but reside in the community. States that do not include this optional category may cover similar children under a home and community-based waiver. As Congress spoke only to those children eligible through 1902(c)(3) in the BBA, these criteria only apply to such children when the optional eligibility category is used.

³ Title V of the Social Security Act provides formula block grants to 59 States and territories to develop service systems for women and children. A minimum of 30 percent of the block grant funds must be used to "provide and promote family centered, coordinated care for children with special health care needs and to facilitate the development of community-based systems for such children and their families." State Title V CSHCN programs use a broad range of activities to carry out this responsibility and meet the needs of CSHCN in their state. These activities include: direct service provision of medical, specialty services and enabling services such as case management, consultative services concerning the care of CSHCN, health care management activities at both the individual and systems level, and managing resources, including negotiating and reimbursing providers for specific services and benefits. States should take into consideration that the group of Title V children in the "BBA definition" must be eligible for Medicaid.

⁴ The identification of children with special health care needs is an ongoing process and serves many purposes including enrolling children in the appropriate MCO, assessing their health care needs and assigning them to the appropriate primary care provider, and monitoring quality of care. There are efforts underway to develop efficient tools and strategies for identifying and monitoring children with special health care needs. One strategy is the use of "Living with Illness Screening Tool" which was developed by the Foundation for Accountability (FACCT), Child and Adolescent Health Measurement Initiative (CAHMI). (For additional information, contact www.facct.org). Another tool is the QulCCC (Questionnaire for Identifying Children with Chronic Conditions), which contains 39 questions for the family or care giver (or the 19-question version of this instrument, called QulCCC-R) (For additional information, see R.E. Stein et al, "The Questionnaire for Identifying Children with Chronic Conditions: A Measure Based on a Noncategorical Approach", Pediatrics, (April 1997) pp 513-521). An additional strategy is using Clinical Risk Groups (CRGs), a classification system developed by the National Association of Children's Hospital and Related Institutions (NACHRI) in conjunction with 3M (see Muldoon, J; Neff, J, Gay J, (1997) Profiling Health Service Needs of Populations using Diagnosis Based Classification System, Journal of Ambulatory Care Management, 20, 1-18. These strategies can be supplemented by using administrative data bases (e.g. cost and utilization data, ICD-9 and other diagnostic coding) and aid code analysis to identify children with special health care needs.

⁵ The pediatric standard for care for children with special health care needs is that of a "medical home." A medical home is an approach to providing care that is accessible, family-centered, comprehensive, continuous, coordinated, compassionate and culturally competent. For further information, see the American Academy for Pediatrics, Managed Care and Children with Special Needs: Medical Home Checklist; www.aap.org/advocacy/medhome/resources/medhomechecklist.htm. Families and caregivers of children with special health care needs should be allowed to choose as a medical home either a primary care provider or a specialist with the capacity and expertise to provide primary care services to such children.

⁶ State officials may want to review the technical assistance document "Optional Purchasing Specifications: Medicaid Managed Care for Children with Special Health Care Needs" to develop contract provisions on behalf of these children. These specifications provide illustrative language on covered benefits and delivery of services to children with special health care needs. The specifications were prepared by George Washington University Center for Health Services Research and Policy (CHSRP) with funding from the Health Resources and Services Administration (HRSA) and the March of Dimes Birth Defects Foundation, in collaboration with the Health Care Financing Administration (HCFA), the Substance Abuse and Mental Health Services Administration (SAMSHA) and the Department of Education (DOE). They were reviewed through a series of vetting meetings involving State Medicaid and public health officials, health care providers, managed care organization representatives, consumers and other outside experts. The specifications can be found at the following website: www.gwu.edu/~chsrp.

⁷ Title V agencies can assist in monitoring the quality of care for CSCCN. Therefore, we recommend that the Single State Agency responsible for administering Medicaid contact the Title V agency to coordinate performance measures for children with special health care needs.

Attachment C

Summary of EPSDT Changes in New MCO CRA

The Amended and Restated Contractor Risk Agreement that took effect July 1, 2001 includes several new requirements intended to enforce existing EPSDT screening requirements and focus attention on increasing screening rates. Contractual requirements that have been added since last July are described below. The same requirements exist in the TennCare Select Agreement unless stated otherwise.

1. Provider Education and Monitoring.

To support the accurate identification of EPSDT services, all MCOs must agree to educate primary care providers to appropriately code EPSDT services, and encourage them to submit the appropriate diagnosis codes when EPSDT services are performed and billed with an evaluation and management procedure code. The intent of this provision is to ensure accurate identification of all EPSDT screenings that have occurred. The HCFA-416 identifies evaluation and management procedure codes as EPSDT only when used in conjunction with evaluation and management diagnosis codes.

2. EPSDT Penalty/Award Program

Amended and Restated CRA

To encourage significant improvement in EPSDT screening rates, a financial incentive equivalent to \$0.32 per member per month (PMPM) will be paid for the achievement of four levels of performance.

Each MCO that improves its Adjusted Periodic Screening Percentage (APSP) by 10 percentage points will receive an incentive payment of \$0.32 PMPM. In addition, each MCO that achieves an APSP of at least 60 percent will receive an incentive payment of \$0.32 PMPM. A third and fourth payment can be earned for each additional ten (10) percentage point increase over 60 percent and up to 80 percent, the EPSDT benchmark level of performance.

The APSP is calculated by multiplying the EPSDT screening ratio, calculated in accordance with specifications for the HCFA-416 report, by the percentage of the required seven (7) components of the EPSDT exam that are completed as determined through a statistically valid sample of medical records of the MCO's enrollees. The medical record review is to be conducted by TENNCARE.

To discourage decreases in EPSDT screening rates, each MCO with an APSP less than the minimum required rate will be required to pay a penalty. The minimum required APSP for calendar year 2001 will be the average APSP for federal fiscal year 2000. The minimum required rate will be revised annually by TENNCARE to propel increases in screening rates from year to year. The penalty amount is equal to 0.40% of the MCO's capitation payments for the applicable 12-month measurement period.

This penalty and award system differs slightly for MCOs that select the new risk-sharing Option 2 being offered to all risk-MCOs as of July 1, 2001. Under this option, the MCO agrees to place two percentage points of its capitation payment at risk based on its performance on ten performance indicators. One of these indicators is EPSDT screening rates and the benchmark level of performance is 80%. Twenty percent of the two percentage points (or 0.40% of the capitation payment – same as above) is at risk for EPSDT. A portion of the funds allocated to EPSDT can be earned after the CONTRACTOR demonstrates at least a 10 percentage point improvement in screening rates.

TennCare Select Agreement

Since the administrator for TennCare Select is not at risk, the penalty and award language related to EPSDT screening rates varies under the TennCare Select Agreement include.

To encourage significant improvement in EPSDT screening rates, the CONTRACTOR may recommend a program designed to increase screening rates through the use of financial incentives. TennCare must approve the program design and amount of any payments prior to distribution.

There are also a number of performance guarantees in the Select Agreement related to EPSDT intended to encourage improvement in timeliness of EPSDT screens and screening rates.

Revised Remedial Plan

Beginning September 1, 2001, the CONTRACTOR agrees to be bound by the performance guarantees identified below. These measures are specific to children in state custody.

a. Timeliness of Care for the Revised Remedial Plan

Initial EPSDT exams completed within 21 days of placement in custody, when the following occurs: (1) timely notification of enrollment (within 48 hours), and (2) DCS has scheduled appointment within three (3) days of placement in custody

Penalty for Non-compliance:	\$1000 per occurrence
Measurement:	DCS notification and encounter data

b. EPSDT compliance rate for the Revised Remedial Plan

A 100% EPSDT screening compliance rate including all seven components, unless reasons for missing components are appropriately documented

Penalty for Non-compliance:	\$500 per child with an incomplete or missing EPSDT exam
Measurement:	Medical record review

General Population

The following performance guarantee applies to other children enrolled in TennCare Select.

EPSDT	
Guarantee	10 percentage point improvement over average MCO fiscal year 2000 APSP screening rate for SSI children; and 10 percentage point improvement over average fiscal year 2000 APSP EPSDT screening rate for all other children (not applicable to Revised Remedial Plan population).
Definition	The percentage of eligible children who receive complete EPSDT screens in a year. This percentage is calculated by multiplying (1) the annual percentage of children who receive a screening by (2) the percentage of the required seven components that are contained in a statistically valid sample of EPSDT screens.
Penalty	\$10,000 for each full percentage point below the required increase.
Monitoring Tool	Screening rate measured and reported annually. Results of independent medical chart review conducted by an entity designated by the state applied to calculate APSP.

3. Focused Study Requirement

All MCOs are required to conduct a continuous evaluation and study of access to EPSDT services for individuals less than twenty-one (21) years of age. A copy of the study design must be submitted to TENNCARE for review and approval within ninety (90) days of the effective date of the new Agreement. The

information provided through these studies will be used to identify Best Practices.

4. EPSDT Safety-Net Providers

There are several new contract requirements related to provider network composition that are intended to support access and availability of providers for children. First, any MCO that has an adjusted periodic screening percentage of less than eighty percent (80%) is required to contract with each Local Health Department for the provision of EPSDT services in the community service area(s) in which it is authorized to serve. Further, the contract stipulates a minimum payment rate that must be paid to Health Departments for EPSDT services (85% of 2001 Medicare, updated annually).

The MCO Agreement also states that the Local Health Department must agree to submit encounter data timely to the MCO and that the MCO must agree to timely process claims for payment and prohibits the MCO from requiring the Local Health Department to obtain authorization to provide EPSDT services (The Local Health Department has the right to terminate an agreement for cause with thirty days advance notice). These provisions are intended to ensure receipt of data and minimize any barriers to timely provisions of services.

The MCO Contractor Risk Agreement that was executed last July stated that standards and measures for accessibility and availability would be added to the revised Agreement. The Restated and Amended CRA and TennCare Select Agreement include Terms and Conditions for access and availability and these have been supplemented by specifying minimum requirements for specialty services. With respect to children's services, the revised Agreement requires that each MCO have a contractual arrangement with at least one tertiary care center in each Grand Region that it serves, for the following essential hospital services: neonatal, perinatal, pediatric, trauma, and burn. Further, each MCO is required to contract with all Centers of Excellence for children in, or at risk of state custody.

MCOs are also required to establish provider agreements with each of nine physician specialists in specific areas of the state that were identified by TennCare as major focal points for the delivery of specialty services.

Finally, TennCare Select is required to include in the Best Practice Network pediatric sub-specialists in each of the five catchment areas in the state that includes each type of pediatric sub-specialist with admitting privileges at the catchment area tertiary pediatric center.

Attachment D

Contract Compliance Actions RE: EPSDT

EPSDT SEMIANNUAL REPORT

2001

BUREAU OF TENNCARE OFFICE OF CONTRACT DEVELOPMENT AND COMPLIANCE

MONITORING ACTIVITIES (Key Area #5)

January, 2001

DIVISION	PROJECT	REVIEW DATE	COMPLIANCE CRITERIA	STATUS/COMMENTS	OGDC CORRECTIVE ACTION PLAN
Contract Compliance	4 th Quarter 2000 Update Specialty Provider Review	1/30/01	Provide PCPs and Case Managers with quarterly update of specialty providers	All MCCs provided acceptable documentation with the exception of Blue Cross/Blue Shield	Assessed liquidated damages - Blue Cross/Blue Shield
Contract Compliance	Withhold - Contractor Qualification, Service Requirements Complaints, Appeal System Requirements - <i>Tennessee Coordinated Care Network</i>	1/01	Correct deficiencies	On-going review	Review within 30 days

February, 2001

DIVISION	PROJECT	REVIEW DATE	COMPLIANCE CRITERIA	STATUS/COMMENTS	OGDC CORRECTIVE ACTION PLAN
TennCare Medical Director	Corrective Action Plan - EPSDT coding of Office Visits - <i>OmniCare</i>	2/7/01	Correct deficiencies	Corrected within specified timelines, no liquidated damages assessed	N/A
Quality Oversight	Corrective Action Plan - EPSDT Encounters - January-July 2000 - <i>Memphis Managed Care</i>	2/20/01	Correct deficiencies	Corrected within specified timelines, no liquidated damages assessed	N/A
Quality Oversight	Corrective Action Plan - EPSDT Encounters - January-July 2000 - <i>Blue Cross/Blue Shield</i>	2/20/01	Correct deficiencies	Corrected within specified timelines, no liquidated damages assessed	N/A

TennCare Medical Director	Corrective Action Plan - EPSDT encounters/reporting information - <i>Tennessee Coordinated Care Network</i>	2/20/01	Correct deficiencies	Corrected within specified timelines, no liquidated damages assessed	N/A
Contract Compliance	Withhold - Contractor Qualification, Service Requirements Complaints, Appeal System Requirements - <i>Tennessee Coordinated Care Network</i>	2/01	Correct deficiencies	On-going review	Review within 30 days

March, 2001

DIVISION	PROJECT	REVIEW DATE	COMPLIANCE CRITERIA	STATUS/COMMENTS	OCDC CORRECTIVE ACTION PLAN
Contract Compliance	Withhold - Contractor Qualification, Service Requirements Complaints, Appeal System Requirements - <i>Tennessee Coordinated Care Network</i>	3/01	Correct deficiencies	On-going review	Review within 30 days

April, 2001

DIVISION	PROJECT	REVIEW DATE	COMPLIANCE CRITERIA	STATUS/COMMENTS	OCDC CORRECTIVE ACTION PLAN
Provider Network	Plan of Correction - Prenatal Network - <i>Xantus</i>	4/27/01	Correct deficiencies	Corrected within specified timelines, no liquidated damages assessed	N/A
Provider Network	Corrected Action Plan - Prenatal Network Deficiencies - <i>Blue Cross/Blue Shield</i>	4/30/01	Correct deficiencies	Corrected within specified timelines, no liquidated damages assessed	N/A
Contract Compliance	1st Quarter 2001 Update Specialty Provider Review	4/30/01	Provide PCPs and Case Managers with quarterly update of specialty providers	All MCCs provided acceptable documentation with the exception of VHP (did not forward update)	VHP assessed liquidated damages from due date to mailing of next quarter's mailing of provider update
Contract Compliance	Withhold - Contractor Qualification, Service Requirements Complaints, Appeal System Requirements - <i>Tennessee Coordinated Care Network</i>	4/01	Correct deficiencies	On-going review	Review within 30 days

May, 2001

DIVISION	PROJECT	REVIEW DATE	COMPLIANCE CRITERIA	SOURCES/COMMENTS	ODGC CORRECTIVE ACTION PLAN
Quality Oversight	Corrective Action Plan - EPSDT Quarterly Status Report - <i>Preferred Health</i>	5/9/01	Correct deficiencies	Corrected within specified timelines, no liquidated damages assessed	N/A
Quality Oversight	Corrective Action Plan - EPSDT Quarterly Status Report - <i>VUMC</i>	5/11/01	Correct deficiencies	Corrected within specified timelines, no liquidated damages assessed	N/A
Quality Oversight	Corrective Action Plan - EPSDT Screening - <i>John Deere</i>	5/20/01	Correct deficiencies	Corrected within specified timelines, no liquidated damages assessed	N/A
Quality Oversight	Corrective Action Plan - EPSDT Screening - <i>Memphis Managed Care</i>	5/20/01	Correct deficiencies	Corrected within specified timelines, no liquidated damages assessed	N/A
Quality Oversight	Corrective Action Plan - EPSDT Screening - <i>VUMC</i>	5/20/01	Correct deficiencies	Corrected within specified timelines, no liquidated damages assessed	N/A
Quality Oversight	Corrective Action Plan - EPSDT - Outreach Planning - <i>Xantus</i>	5/20/01	Correct deficiencies	Corrected within specified timelines, no liquidated damages assessed	N/A
Quality Oversight	Corrective Action Plan - EPSDT - Outreach Planning - <i>Preferred Health</i>	5/20/01	Correct deficiencies	Corrected within specified timelines, no liquidated damages assessed	N/A
Quality Oversight	Corrective Action Plan - EPSDT - Outreach Plan - <i>Blue Cross/Blue Shield</i>	5/21/01	Correct deficiencies	Corrected within specified timelines, no liquidated damages assessed	N/A
Contract Compliance	Withhold - Contractor Qualification, Service Requirements Complaints, Appeal System Requirements - <i>Tennessee Coordinated Care Network</i>	5/01	Deficiencies corrected	Withhold released	N/A
Contract Compliance	Withhold - Hospital Network - <i>Tennessee Care Coordinated Network</i>	4/01	Correct deficiencies	On-going review	Review in 30 days

June, 2001

DIVISION	PROJECT	REVIEW DATE	COMPLIANCE/COMMENTS	STATUS/COMMENTS	OCDC CORRECTIVE ACTION PLAN
Provider Network	Plan of Correction – Prenatal Network - <i>Tennessee Care Coordinated Network</i>	6/14/01	Correct deficiencies	Corrected within specified timelines, no liquidated damages assessed	N/A
Contract Compliance	Withhold – Hospital Network – <i>Tennessee Care Coordinated Network</i>	6/01	Deficiencies Corrected	Withhold Released	N/A

REVIEW OF PROVIDER CONTRACTS FOR EPSDT VIOLATIONS (Key Area #8)

MCC	PROJECT	REVIEW DATE	COMPLIANCE CRITERIA	STATUS/COMMENTS	OGDG CORRECTIVE ACTION PLAN
<i>Universal Care</i>	Provider Agreements	2/2001	N/A	Approved	N/A
<i>Better Health Plan</i>	Provider Agreements	2/2001	N/A	Approved	N/A
<i>Universal Care</i>	Dental Provider Manual	6/2001	EPSTD Compliance	Pending	On-going review
<i>Universal Care</i>	Vision Provider Manual	6/2001	EPSTD Compliance	Pending	On-going review
<i>BC/BS TennCare Select</i>	TennCare Select pages for inclusion in BC Provider Manual	6/19/01	N/A	Approved	N/A
<i>BC/BS TennCare Select</i>	TennCare Select for Best Practice Network (BPN)	6/19/01	N/A	Approved	N/A
<i>BC/BS TennCare Select</i>	BPN-PCP Medical Record Update and Office Medical Records Review Tool	6/20/01	N/A		
<i>BC/BS TennCare Select</i>	TennCare Select pages for inclusion in BC Provider Manual	6/21/01	N/A		

LIQUATED DAMAGES ASSESSED FOR EPSDT SERVICE DIRECTIVES (DFS's)

By MCC

MCC	DESCRIPTION/TOTAL NUMBER OF ASSESSMENTS & SYSTEMIC VIOLATIONS	TOTAL AMOUNT OF LIQUIDATED DAMAGE ASSESSMENT
<i>January, 2001</i>		
Tennessee Coordinated Care Network	Dental Services - 1	\$30,000
Tennessee Coordinated Care Network	Specialists Care - 3	\$88,500
Xantus	Dental Services - 1	\$88,000
<i>February, 2001</i>		
BC/BS	Pharmacy Services - 2	\$ 9,000
Tennessee Coordinated Care Network	Specialists Care - 4	\$63,000
Tennessee Coordinated Care Network	Continuation of Care - 1	\$ 1,500
<i>March, 2001</i>		
Premier Behavioral System	Residential Care - 1	\$ 1,500
Tennessee Coordinated Care Network	Specialists Care - 1	\$ 1,500
Tennessee Coordinated Care Network	PCP - 1	\$ 1,500
<i>April, 2001</i>		
Tennessee Coordinated Care Network	Dental Services - 3	\$72,000
Tennessee Coordinated Care Network	Lab work/test - 1	\$24,000
Tennessee Coordinated Care Network	PCP - 3	\$19,000
Tennessee Coordinated Care Network	DME - 1	\$ 1,000
Tennessee Coordinated Care Network	Continuation of Care - 1	\$18,000
Tennessee Coordinated Care Network	Pharmacy Services - 1	\$ 1,000
Tennessee Coordinated Care Network	Specialist Care - 10	\$98,500
Xantus	DME - 1	\$27,500
Premier Behavioral System	Residential Care - 1	\$ 500
Tennessee Behavioral Health	Therapeutic Foster Care - 1	\$ 2,500
<i>May, 2001</i>		
Tennessee Behavioral Health	Substance Abuse/AD - 1	\$ 5,500
Tennessee Coordinated Care Network	Specialist Care - 3	\$16,500
Tennessee Coordinated Care Network	Continuation of Care - 1	\$ 4,000
Tennessee Coordinated Care Network	Hospital Services - 2	\$14,500
Tennessee Coordinated Care Network	Dental Services - 1	\$ 7,500
BC/BS	Pharmacy Services - 1	\$ 1,000
Premier Behavioral System	Residential Care - 1	\$ 500
<i>June, 2001</i>		
Tennessee Coordinated Care Network	Dental Services - 2	\$ 4,500
	TOTAL NUMBER OF ASSESSMENTS = 50	TOTAL AMOUNT ASSESSED = \$602,500.00

SUMMARY OF LIQUATED DAMAGES ASSESSED FOR EPSDT SERVICE DIRECTIVES (DFS'S)

By MCC

Deficiency	OminiCare	BC/BS	John Deere	TLC	Xanadu	PHP	NGCN	YHP	Penile	TBH	TOTALS
Dental Services	0	0	0	0	0	0	1	0	0	0	1
Specialist Care	0	0	0	0	0	0	21	0	0	0	21
Pharmacy Services	0	3	0	0	0	0	1	0	0	0	4
Continuation of Care	0	0	0	0	0	0	3	0	0	0	3
Residential Care	0	0	0	0	0	3	0	0	0	0	3
PCP	0	0	0	0	0	0	3	0	0	0	3
Lab work/test	0	0	0	0	0	0	3	0	0	0	3
DME	0	0	0	0	0	0	1	0	0	0	1
Therapeutic Foster Care	0	0	0	0	0	0	1	0	0	0	1
Substance Abuse	0	0	0	0	0	0	0	0	0	1	1
Hospital Services	0	0	0	0	0	0	0	0	0	1	1
TOTALS	0	3	0	0	2	3	40	0	0	2	50

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Attachment E

Quarterly Outreach Reports

SUMMARY OF TENNCARE MCO EPSDT QUARTERLY REPORT FOURTH QUARTER 2000

Quarterly Enrollee Demographics	Access Med Plus	Blue Care	John Deere	Omni Care	PHP	TLC	VHP	Xantus
Number of enrollees <21 years of age	150115	250584	21878	24454	42494	44340	7334	33594
Number of enrollees <21 years of age having special needs (1)	107	5338	55	68	---	16	71	955
Number of enrollees <21 years of age case managed	86	65031	55 (7)	320 (8)	---	335	10	2044
Number of newly eligible enrollees during the quarter <21 years of age	8790	9158	2659	750	4499	3064	398	841
Number of individuals informed of availability of EPSDT services during the quarter.								
Parent/Guardian of newly eligible child	8790	9158	2659	286	4499	680	392	106 (11)
TennCare eligible pregnant women	1591	550	1	0	---	1000	0	100
Families in WIC program	0	N/A	---	0	---	0	0	0
Institutional Administrators	0	5	---	0	---	58	0	0
Other	0	---	---	0	---	11195 Birthday Reminder Cards	---	0
OUTREACH SERVICES								
A. Processes								
Methods of Informing enrollees of EPSDT services during the quarter.								
Outreach Representative	X	X	---	X	---	---	X	X
Public Service Announcements	---	---	---	---	---	---	---	---
Community Awareness Program	---	X	---	---	---	---	---	---
Member Services Representative	X	X	---	---	X	X	X	---
Telephone	---	X	---	---	---	---	---	---
Face to Face	X	X	---	X	X	X	X	---
New Member Letter	X	X	---	---	---	---	---	---
Member Newsletter	X	---	X	X	---	---	---	---
Posters, Flyers, Brochures	X	X	---	X	X	X	X	---
Member Handbook Annually	X	X	---	X	---	X	X	---
Other	X	X	X	X	---	X	X	X
B. Members & Providers								
Activities utilized to inform members/providers of availability of EPSDT services this quarter.								
Reminder Cards	[2]	Orientation Video	---	Health Fairs	---	Preventive Health Staff	---	---
Brochures	---	X	---	X	X	X	X	X
Posters	X	X	---	X	---	X	X	X
Newsletters	---	X	---	---	---	---	---	---
New Member Letters	---	X	X	X	X	X	X	---
Provider Newsletter	X	---	X	X	X	X	X	---
Provider/EPSDT Rep Visits to Provider	---	X	X	X	---	X	X	---
		0		119	---	---	6	---

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SUMMARY OF TENNCARE MCO EPSDT QUARTERLY REPORT FOURTH QUARTER 2000

Letters	Access Med Plus	Blue Care	John Deere	Omni Care	PHP	TLC	VHP	Xantus
Telephone	X	X	---	---	---	X	X	---
Provider Manual	---	X	---	200 (members)	---	---	---	---
Other	---	X	X	X	X	X	X	---
Number of new member information regarding EPSDT sent within time frame:	(3)	(6)	---	476 (9)	Info Week	Health Fairs	---	---
Less than 15 Days	---	---	X	---	X	14194 (98%)	---	---
15 to 30 Days	X	11235	---	750	---	289 (2%)	---	---
30 to 45 Days	---	---	---	---	---	0	---	106 (11)
45 to 60 Days	---	---	---	---	---	0	392	---
>60 Days	---	---	---	---	---	0	---	---
Number of new member letters returned undelivered during the quarter.	166	N/A	N/A	36	0	Approx 120	3	0 (11)
What actions are taken to address returned mail?	---	---	---	X	---	X	---	X (12)
Contact enrollee by telephone	X	X	X	PassPort address verification system (TransUnion)	---	Contact PCCM Office	2 members disenrolled	X (12)
Remailing	---	---	---	---	---	---	---	---
Other	(4)	Change address in system when a new one is identified	Notify TennCare	431 Known	0	0	0	0
How many enrollees contacted this quarter declined EPSDT services?	None	N/A	N/A	---	---	---	---	---
What procedures have you used this quarter for contacting members who are:	---	---	---	---	---	---	---	---
Blind	None	---	---	Outreach Calls	---	---	Member Handbook in Braille	(13)
Illiterate	None	---	---	Outreach Calls	---	---	Use 6th grade level in all handouts	(13)
Deaf	TDD Line	---	---	TDD line	---	---	0	(13)
Non-English Speaking	AT&T Language Line	AT&T Language Line is used when a member calls customer service	John Deere has Spanish/Hispanic and Bosnian interpreters available as well as the AT&T language line	AT&T Language Line	---	Translation of brochures, flyers	Phone Service (Language)	Developed list of employees who are fluent in languages other than English to facilitate interpretation
What process is in place to monitor the effectiveness of the procedures for contacting members who are blind, illiterate, deaf or non-English speaking?	To be determined	No measures for effectiveness of the AT&T language line have been developed	Members have access to the TTY/TDD #1.800.884.4327	Quarterly reports on AT&T language line usage	None in place at this time	See attached procedures	Under Development	None at present time
COORDINATION WITH OTHER AGENCIES	---	---	---	---	---	---	---	---
Coordinated EPSDT services with the following programs during the quarter.	---	---	---	---	---	---	---	---
Head Start	---	X	---	---	---	---	---	---

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SUMMARY OF TENNCARE MCO EPSDT QUARTERLY REPORT FOURTH QUARTER 2000

Educational Systems	Access Med Plus	Blue Care	John Deere	Omni Care	PHP	TLC	VHP	Xantus
WIC	---	X	---	---	---	X	---	---
AFDC	---	X	---	---	---	---	---	---
Day Care Licensing Agency	---	X	---	---	---	---	---	---
Health Department	---	X	---	---	---	---	---	---
Other	X	X	---	---	---	---	---	---
INTERNAL TRACKING SYSTEM	---	---	---	---	Homeless Coalition	Early Child Health Outreach	Homeless Shelter	---
Number of members determined to be past due for EPSDT services during the quarter	N/A	49637	20312	3737	---	14190	Unknown	[14]
Number of records reviewed for compliance with EPSDT standards	N/A	N/A	9	144	---	0	0	[15]
SCREENING SERVICES								81
Number of well-child screenings during the quarter	18370	31840	1800	1182	286	5727	158	4213
Number of vision screenings during the quarter	4810	654	56	497	233	34	12	49
Number of hearing screenings during the quarter	369	759	14	61	0	169	4	112
Number of dental screenings during the quarter	15441	29675	1472	6182	---	3298	139	4046
PAST DUE SERVICES AND COMPLIANCE RATES								
How are enrollees informed who have not had specific EPSDT services, including the following:								
WELL-CHILD VISITS								
Reminder letter/card	---	X	X	X	---	X	X	X
Telephone	---	---	---	---	---	---	---	---
Other	[5]	---	---	See Additional Activities	[10]	---	---	---
ADOLESCENT WELL-VISITS								
Reminder letter/card	---	X	X	X	---	X	X	X
Telephone	---	---	---	---	---	---	---	---
Other	[5]	---	---	---	[10]	---	---	---
CHILDHOOD IMMUNIZATIONS								
Reminder letter/card	---	X	X	X	---	X	X	X
Telephone	---	---	---	---	---	---	---	---
Other	[5]	---	---	---	[10]	---	---	---
ADOLESCENT IMMUNIZATIONS								
Reminder letter/card	---	X	X	X	---	X	X	X
Telephone	---	---	---	---	---	---	---	---
Other	[5]	---	---	---	[10]	---	---	---
DENTAL CHECK-UPS								
Reminder letter/card	---	X	X	X	---	X	X	X
Telephone	---	---	---	---	---	---	---	---
Other	[5]	Mobile Clinics	---	---	[10]	---	---	---

Division of Quality Oversight
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Internal Report, Not For Distribution

SUMMARY OF TENNCARE MCO EPSDT QUARTERLY REPORT FOURTH QUARTER 2000

How are member compliance rates monitored for preventive screenings and immunizations?	Access Med Plus	Blue Care	John Deere	Omni Care	PHP	TLC	VHP	Xantus
Provider Reports	X							
MCO Reports	X	X	Administrative Data Immunization Report	X			X	
Other		Encounter Data	TennCare Audit, MCO Medical Record Reviews		Data Base		Chart Review	
Is there a mechanism in place to assure that non-emergency transportation is provided to enrollees?								
Yes	X	X	X	X	X	X	X	X
No								
SPECIAL NOTATIONS								
[1] Identified as congenital conditions, developmental delays, catastrophic or long term illnesses, etc								
[2] Monthly member letters, Mom 2-B-Club letters								
[3] Provider mailing of EPSDT Chart Forms								
[4] Customer Services documents return of new member packets in the member notes. When the member calls, the CSR will inform them that the new member packet was returned undeliverable. The CSR gets the correct mailing address, processes this information according to policy, and sends a request for another new member packet to be sent to the member.								
[5] Reminders of well-child and adolescent well visits, which also include both childhood and adolescent immunizations as well as reminders regarding dental check-ups occur on a limited basis through the outreach workers in the Health Promotion/Disease Prevention Department								
[6] Provider guidelines (bcbst.com). Orientation sessions, Health fairs, baby showers.								
[7] JDH does not currently report special needs separately--those special needs individuals who are in case management are included in the case management number.								
[8] 250 in state custody								
[9] OmniCare's Preventive Care Initiative Program								
[10] Not Yet Implemented								
[11] Number reflects December 2000 total only. Previous months numbers were unavailable at the time of this draft.								
[12] Currently not performing these functions. This process should be developed and implemented by 2nd Qtr 2001								
[13] Researching options to address these areas using pictures and Braille								
[14] Participating in the EPSDT Provider Training and the TennCare Homeless Outreach programs								
[15] Please see action plan. Target date for the database for proactive identification and notification targeted for the end of 1st Qtr 2001								
ADDITIONAL EPSDT ACTIVITIES COMMENTS								
ACCESS MED PLUS: TCCN staff serve on the EPSDT Task Force with Metro Health Department								
OMNI: The Health Outreach Department initiated outgoing calls to all parents of two-year old members known to have a telephone number. 200 members were contacted in this fashion. It should be noted that the outgoing calls were made to all children, not just those enrolled in the OmniKids incentive program. The OmniKids incentive program had 533 children age 6 and under enrolled for the quarter.								
PHP: Working with the Homeless Coalition of Knoxville to train staff members of Homeless and Domestic Violence Shelters on TennCare and how to access EPSDT services for this population								
TLC: EPSDT Coordinators Meeting Nashville 11/20/00								

SUMMARY OF TENNCARE MCO/BHO EPSDT QUARTERLY REPORT FIRST QUARTER 2001

Quarterly Enrollee Demographics	Access Med Plus		Blue Care	John Deere	Omni Care	PHP	TLC	VHP	Xantus	Premier	TBH
	Plus										
Number of enrollees <21 years of age	155,030		256,944	21,881	21238	45,277	46,037	7,591	64308	147,017	326,433
Number of enrollees <21 years of age having special needs(s)	132		74,181	63 (14)	239	...	16	71	910	5,185	9,152
Number of enrollees <21 years of age case managed	111		Not Available	63	319	106	401	10	337	1,791	3,525
Number of newly eligible enrollees during the quarter <21 years of age	3,053		14,930	1613	708	3570	2,626	448	4664	5,483	9,202
Number of Individuals Informed of availability of EPSDT services during the quarter.	3,053		14,930	1613	391	3570	723	448	4664	...	...
Parent/Guardian of newly eligible child	1190		3,288	4	0	283	1,322	0	390	...	...
TennCare eligible pregnant women	503		Don't Track	...	0	...	0	0	...	...	...
Families in WIC program	0		8	...	0	...	2	0	...	...	...
Institutional Administrators	0		5,554 (6)	...	0	...	29 (24)	...	...	...	...
Other	0		...	...	...	...	...	...	...	...	...
OUTREACH SERVICES											
A. Processes											
Methods of Informing enrollees of EPSDT services during the quarter:											
Outreach Representative	X		X	...	X	...	...	X	X	...	...
Public Service Announcements	...		...	...	...	...	...	...	...	...	...
Community Awareness Program	...		X	...	...	...	X	X	X	...	...
Member Services Representative	X		X	...	...	X	X	X	...	...	...
Telephone	...		X	...	...	X	X	...	...	...	...
Face to Face	X		X	...	...	X	X	...	...	...	...
New Member Letter	X		X	...	...	X	X	...	...	...	...
Member Newsletter	X		X	X	X	X	X	X	X	...	...
Posters, Flyers, Brochures	X		X	X	X	X	X	X	X	...	...
Member Handbook Annually	X		X	...	X	...	X	X	X	...	...
Other	X		X	X	X	...	X	X	X	...	...
B. Members & Providers	(2)		(7)	...	...	...	(25)	...	...	...	...
Activities utilized to inform members/providers of availability of EPSDT services this quarter.											
Reminder Cards	...		X	...	X	X	X	X	...	...	...
Brochures	X		X	...	X	...	X	X	...	...	...
Posters	...		X	...	X	...	X	...	X	...	...
Newsletters	...		X	...	...	...	...	...	...	...	...
New Member Letters	X		X	X	X	X	X	X	...	X	X
Provider Newsletter	...		X	X	X	X	X	X	X	...	...
Provider/EPSDT Rep Visits to Provider Letters	X		96	X	...	412	...	0	...	X	X
Telephone	...		X	...	1260 (members)	X	X	X	...	...	...
Provider Manual	...		X	X	X	X	X	X	...	...	...

Division of Quality Oversight
December 2000 Edition
May 14, 2001

Internal Report, Not For Distribution

SUMMARY OF TENNCARE MCO/BHO EPSDT QUARTERLY REPORT FIRST QUARTER 2001

	Access Med Plus	Blue Care	John Deere	Omni Care	PHP	TLC	VHP	Xantus	Premier	TBH
Other	X	"See Notebooks"	...	770 Preventive Care Initiative Program	Provider Meetings	Health Fairs, Flyers	...	...	...	...
Number of new member information regarding EPSDT sent within time frame:										
Less than 15 Days	...	0	X	...	100%	[26]	...	...	...	...
15 to 30 Days	5,629	27,087	...	2169	...	75%	...	...	...	...
30 to 45 Days	...	0	...	...	...	20%	...	...	...	...
45 to 60 Days	...	0	...	...	...	5%	...	3774	...	...
>60 Days	...	0	...	...	...	0	448	440	...	...
Number of new member letters returned undelivered during the quarter:	188	"Don't Track"	Data not available	107	0	0	...	450	...	...
What actions are taken to address returned mail?	...	...	...	...	...	29%	6	245	...	...
Contact enrollee by telephone	...	...	...	...	...	...	...	...	...	...
Remailing	X	X	X	X	[18]	X	...	Yes	...	...
Other	[3]	[8]	"Notify TennCare Bureau"	TransUnion address verification	...	"Contact PCCM office"	X	Yes	...	...
How many enrollees contacted this quarter declined EPSDT services?	None	"Don't Track"	Data not available	655	0	0	0	0	Archive all returns	Archive all returns
What procedures have you used this quarter for contacting members who are:										
Blind	None	[9]	...	Outreach Calls	...	...	[30]	None	...	...
Illiterate	None	[10]	...	Outreach Calls	[20]	...	[31]	None	...	...
Deaf	TDD Line	[11]	...	TDD Line	[20]	...	[32]	None	...	...
Non-English Speaking	Language Line	[12]	[15]	AT&T Line	[20]	[27]	[33]	None	...	...
What process is in place to monitor the effectiveness of the procedures for contacting members who are blind, illiterate, deaf or non English speaking?	"To be determined"	[13]	[16]	...	None	[28]	...	[34]	...	...
COORDINATION WITH OTHER AGENCIES										
Coordinated EPSDT services with the following programs during the quarter:										
Head Start	...	X	...	X	...	X	...	...	See action plan	See action plan
Educational Systems	...	X	...	X	...	X	...	...	...	...
WIC	...	X	...	X	...	X	...	...	...	...
AFDC	...	X	...	X	...	...	...	...	...	...
Day Care Licensing Agency	...	X	...	X	...	...	...	...	...	...
Health Department	X	X	...	X	...	X	X	X	See action plan	See action plan
Other	X	Homeless Coalition	[29]	Homeless Shelter	[35]

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SUMMARY OF TENNCARE MCO/BHO EPSDT QUARTERLY REPORT FIRST QUARTER 2001

INTERNAL TRACKING SYSTEM	Access Med Plus	Blue Care	John Deere	Omni Care	PHP (21)	TLC	VHP	Xantus	Premier	TBH
Number of members determined to be past due for EPSDT services during the quarter	"NA"	50,760	...	3036	...	3,007	"Unknown-- Tracking Under Development"	[36]	N/A	N/A
Number of records reviewed for compliance with EPSDT standards	"NA"	"Not Available"	16	0	...	82	0	91	N/A	N/A
SCREENING SERVICES										
Number of well-child screenings during the quarter	13,299	21,059	2093	3157 (17)	105,621	13,960	290	3193	N/A	N/A
Number of vision screenings during the quarter	3,742	568	25	717	22,154	26	0	11	N/A	N/A
Number of hearing screenings during the quarter	197	767	11	4 (17)	406	150	0	10	N/A	N/A
Number of dental screenings during the quarter	13,553	19,415	1647	2159	3,481	3,536	202	1678	N/A	N/A
PAST-DUE SERVICES AND COMPLIANCE RATES										
How are enrollees informed who have not had specific EPSDT services, including the following:										
WELL-CHILD VISITS										
Reminder letter/card	...	X	X	X	...	X	X	...	...	...
Telephone	...	...	...	...	...	...	...	...	...	...
Other	[4]	...	...	...	[22]	...	...	...	...	...
ADOLESCENT WELL-VISITS										
Reminder letter/card	...	X	X	X	...	X	X	...	...	...
Telephone	...	...	...	...	...	...	...	...	...	...
Other	[4]	...	...	...	[22]	...	...	...	...	...
CHILDHOOD IMMUNIZATIONS										
Reminder letter/card	...	X	X	X	...	X	X	...	...	...
Telephone	...	...	...	...	...	...	...	...	...	...
Other	[4]	...	...	...	[22]	...	...	...	...	...
ADOLESCENT IMMUNIZATIONS										
Reminder letter/card	...	X	X	X	...	X	X	...	...	...
Telephone	...	...	...	...	...	...	...	...	...	...
Other	[4]	...	...	...	[22]	...	...	...	...	...
DENTAL CHECK-UPS										
Reminder letter/card	...	X	X	X	...	X	X	...	...	...
Telephone	...	X	...	X	...	...	...	...	...	...
Other	[4]	Mobile Clinics	...	...	[22]	...	...	...	...	...
How are member compliance rates monitored for preventive screenings and immunizations?										
Provider Reports	[5]	X	...	...	...	X	X	...	...	...
MCO Reports	X	X	"Administrative Data Immunization Report"	X	...	...	...	X	...	...

SUMMARY OF TENNCARE MCO/BHO EPSDT QUARTERLY REPORT FIRST QUARTER 2001

Access Med Plus

Other	Blue Care	John Deere	Omni Care	PHP	TLC	VHP	Xantus	Premier	TBH
Is there a mechanism in place to assure that non-emergency transportation is provided to enrollees?	"Bureau of TennCare HCFA 416 Reports, encounter data"	"TennCare Audit, MCO Medical Record Reviews"	...	[23]	...	Chari Reviews	...	...	...
Yes	X	X	X	X	X	X	X	X	X
No	...	...	...	...	...	...	...	...	...

SPECIAL NOTATIONS

- Identified as congenital conditions, developmental delays, catastrophic or long term illnesses, etc
- Monthly member letters, Mom 2-B-Club letters
- Customer Services documents return of new member packets in the member notes. When the member calls, the CSR will inform them that the new member packet was returned undeliverable. The CSR gets the correct mailing address, processes the information according to policy, and sends a request for another new member packet to be sent to the member.
- Reminders of well-child and adolescent well visits, which also include both childhood and adolescent immunizations as well as reminders regarding dental check-ups occur on a limited basis through the outreach workers in the Health Promotion/Disease Prevention Department
- Ad Hoc Reports
- Face-to-Face Client Advocacy Activities 149 enrolled in Bright Futures and were sent targeted info on EPSDT
- Outbound Call Program. An attempt is made to contact all new members by telephone within 30 days of enrollment. This method of contact is unreliable because research has to be conducted to find telephone numbers since this is not a data element sent to Blue Care on the eligibility files. If we cannot find a telephone number, we cannot call the member
- Change address in system when new one is identified
- Member handbook on tape
- Reps may have an occasion to explain handbook as requested
- None
- AT&T Language line is used when a member calls customer service. Handbooks and Nurse Talk Audio Library are available in Spanish
- No measures for effectiveness of the AT&T language line have been developed
- JDH does not currently report special needs separately--those special needs individuals who are in case management are included in the case management number
- John Deere has Spanish/Hispanic and Bosnian interpreters available as well as the AT&T language line
- Members have access to the TTY/TDD# 1-800-884-4327
- Dates of service plan only (see additional information)
- If no address is in file and phone number is on file
- If new address is available
- None other than normal distribution of material or speaking with member on the phone or a third party used as a go between
- 74 Number of on-site office record reviews conducted
- This information is not currently tracked [by PHP]
- Claims data is loaded in a warehouse that can be queried for specific information
- Teachers, Early childcare students/educator interns
- Staff Preventive Health
- Approx. 15,652 new members
- Translation of brochures, flyers, etc
- Same as last report. Procedures for handling of calls and handling of non-English speaking callers

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SUMMARY OF TENNCARE MCO/BHO EPSDT QUARTERLY REPORT FIRST QUARTER 2001

Access Med
Plus

Blue Care John Deere Omni Care PHP

TLC

VHP

Xantus

Premier

TBH

[29] Educational Systems: Schools and head start centers are encouraged to schedule EPSDT presentations for teachers and parents. Ten presentations have been conducted this quarter. EPSDT information is also shared at school health fairs. Health Department: Preventive Health staff is an active participant with the Memphis and Shelby County Immunization Council. TLC staff helped facilitate the first Council newsletter and assisted with the coordination and participated in the activities for National Infant Immunization Week.

[30] Member handbook available in Braille.

[31] Use 6th grade level in all handouts

[32] TOD Phone Service Available

[33] ATT Language Line Services

[34] By fourth quarter 2001, a draft policy/procedure will be routed for review on programs designed to address the above.

[35] Homeless Children's Coalition Meetings

[36] XHT's Information Technology Department is currently programming our Preventive Screening and Tracking database, which was slated for completion by the end of the First Quarter. The database is an integral part of XHT's notification of members that preventive services are due or past due depending on their age. This includes children 20 and younger for all EPSDT Services. We hope to have the programming completed and the testing phase to follow shortly thereafter.

[37] All recipients of member newsletter

ADDITIONAL EPSDT ACTIVITIES COMMENTS

ACCESS MED PLUS: TCCN staff serve on the EPSDT Task Force with Metro Health Department. Staff attended the EPSDT Advocacy Training on February 27, 2001 held in Nashville at the Tennessee Preparatory School (TPS). Attendees consisted of individuals from various community and social agencies that work with TennCare children. The Mid-Cumberland Council on Children and Youth (MCCY) sponsored the training.

BLUE CARE: An attempt is made to contact all new members by telephone within 30 days of enrollment. This method of contact is unreliable because research has to be conducted to find telephone numbers since this is not a data element sent to Blue Care on the eligibility files. If we cannot find a telephone number, we cannot call the member. See Notebooks.

OMNI CARE: See attachment

PHP: Although we do not currently track overdue preventive services, we do send out preventive age specific letters during a child's birth month that reminds them of well visit immunization, vision, and dental visit requirements. Every phone call into customer services for members under the age of 21 requires that EPSDT status be asked of the caller. Responses are documented. If the caller needs provider directories or vision or dental directories or assistance obtaining an appointment for necessary services, customer service representatives provide the necessary help and/or material. 1st quarter preventive reminders = 6,878.

TLC: EPSDT Train the Trainer Nashville 1/9/01, Early Child Health Outreach (ECHO) conference call 1/11/01, EPSDT Coordinators Mtg-conference call 2/22/01, EPSDT Provider Trainings 2/23/01, 3/16/01. TLC EPSDT Training Group meetings

VHP: Currently developing and implementing tracking systems, updating database for EPSDT. Have contacted chairperson of the TennCare for Homeless Children Working Group and plan to attend meetings and activities. Plan to continue activities with Davidson County Task Force. Plan to continue internal working relationship with Key Departmental members to increase organization wide coordination and activities related to EPSDT.

XANTUS Attached EPSDT Quarterly Screening Report. Number of Screenings 1st quarter 2001.

PREMIER/TBH: While we can provide basic eligibility information, because we only have information related to a member's status such as priority or non-priority, we do not aggregate other information related to special needs. Currently, we pull information related to a member's TPG status for reporting purposes, but this information is based on <18 rather <21 due to the age limitations of the TPG tool. There is also a significant lag in the compilations of this information as it is based on assessment data, making last quarter's complete information unavailable as of yet. Since every service the BHO tracks is considered an EPSDT service, I can periodically provide information related to duplicated and unduplicated services received by children under 18 as reported by TPG rating. This information is usually available every six months.

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December 2000 Edition
May 14, 2001

Internal Report. Not For Distribution

Attachment F

DCS EPSDT Standards

Subject: EPSDT Standards

20.7

*State of Tennessee Department of Children's Services***Administrative Policies and Procedures: 20.7**

Subject: Early Periodic Screening Diagnosis and Treatment (EPSDT) Standards

Supersedes: DCS 20.7, 10/01/98

Local Policy: No

Local Procedures: No

Training Required: No

Approved by:

A handwritten signature in cursive script, likely belonging to George M. Hester, Jr., is written over the "Approved by:" label.

Effective date: 10/01/1998

Revision date: 04/01/2001

Application

To All Department of Children's Services Youth Development Centers, Community Residential Facilities (Group Homes), Foster Care and DCS Contract Agencies Employees

Authority:

TCA §37-5-106

Policy

Each child/youth must receive required Early Periodic Screening Diagnosis, and Treatment (EPSDT) screenings, within the time frame specified, while in state custody. Every child/youth under the age of 21 is eligible for EPSDT screenings and must receive periodic checkups, even if there is no apparent health problem.

Procedures

- A. EPSDT definition**
1. Early Periodic Screening Diagnosis, and Treatment (EPSDT) is a comprehensive physical, also referred to as a well-child checkup. There are seven components of an EPSDT. They include:
 - a) Comprehensive health and development history;
 - b) Comprehensive unclothed physical exam;
 - c) Age-appropriate immunizations;
 - d) Age-appropriate lab tests;
 - e) Health education;

Subject: EPSDT Standards

20.7

- f) Vision screen, and
 - g) Hearing screen.
2. An EPSDT includes the services previously mentioned, as well as necessary health care, diagnostic services, treatment, and other measures to correct physical and mental conditions discovered by the screening. There are three types of EPSDT physicals:
- a) **Initial History and Physical**, which is a physical for a child entering care within the time frame specified.
 - b) **Periodic Physicals** is the regular routine screening service according to the following schedule:

At birth	4 months	15 months
2-4 days	6 months	18 months
1 month	9 months	24 months
2 months	12 months	Yearly from 3-22 yrs.
 - c) **Interperiodic Physical**. When there is a medical concern the child is not due for a periodic screening, an appointment with the Primary Care Provider (PCP) should be made so the situation can be assessed and the appropriate referral given, i.e. vision, dental, flu, infections, etc.

**B. EPSDT
Physiological
Measurements**

An EPSDT includes the following physiological measurements:

- 1. Height;
- 2. Weight;
- 3. Temperature/pulse/respirations;
- 4. Blood pressure;
- 5. Vision screening, and
- 6. Audiometric screening.

Subject: EPSDT Standards**20.7****C. EPSDT laboratory screenings**

An EPSDT must include the following laboratory screening tests when determined as needed by the clinical practitioner. YDCs and Community Residential Facilities must ensure that youth have the procedures listed below:

1. Dipstick urinalysis;
1. Serology for syphilis;
1. Culture for gonorrhea;
1. PAP smear;
5. Pregnancy test;
6. CBC (Complete Blood Count), and
7. Total cholesterol check.

D. Tuberculosis test

The EPSDT must include a diagnostic test for tuberculosis.

E. Physical examination

1. The clinical practitioner must review the results of the health history, physiological measurements, and laboratory and diagnostic tests and must perform a physical examination and record the results on the specified form.
2. Additional diagnostic procedures or consultations may be ordered at this time, based on identified problems or individual risk factors.
3. In conjunction with the physical examination, the medical practitioner must perform a breast exam on all female youth when applicable.

Subject: EPSDT Standards**20.7****F. Specified time frame for EPSDT to be completed**

1. **Youth Development Centers:** Health care personnel in the youth development center clinic shall complete a comprehensive health history and physical examination during the intake/classification process on each youth within seven (7) calendar days after the arrival at the facility. The clinical practitioner must record the results of the screening on the EPSDT form. Annual EPSDT physicals must follow the periodic physical routine schedule.
2. **DCS Community Residential Program:** The community residential program staff must have made an appointment for a health history and physical examination for the child within fourteen (14) days after the arrival at the facility. If the child is entering the group home from a youth development center and the child has received an EPSDT screen within the last six (6) months, the screening will be considered current. The next screening will be due the next annual date. The community residential program staff must also obtain the following medical records on the youth from the youth development center:

Initial screening;

Social history if applicable, and

Past medical records including past psychologicals, if available.

a) Information to accompany youth to initial epsdt screening:

- ◆ Insurance or TennCare information;
- ◆ Immunization record;
- ◆ Explanation of the medical problem to be addressed, and
- ◆ Release of information and custody order should accompany the child.

b) In addition, the following should accompany the child available:

- ◆ Initial health questionnaire;
- ◆ Social history;
- ◆ Past medical records including past psychological
- ◆ Short Form Assessment for children over five (5);
- ◆ An explanation of the current medical problem and any pertinent medical information that pertains to the problem;
- ◆ PEDS response form, and
- ◆ Pediatric Symptom Checklist (PSC).

c) Staff or contractor to accompany child to initial EPSD screening: The case manager must accompany the youth; the biological parent may accompany if appropriate.

a) Staff or contractor to accompany child on follow up

Subject: EPSDT Standards**20.7****G. Children with presenting illnesses or symptoms**

1. The case manager must inform the Regional Health Advocacy Unit Nurse regarding children entering into state custody who present complex medical conditions. The Regional Health Advocacy Unit nurse will provide assistance and/or consultation regarding provision of medical services. If the nurse feels there is a need to see a doctor, the case manager must make an urgent doctor's appointment, which must be scheduled within 48 hours. Emergency services should be accessed as needed. CPS investigators should follow standard protocols and access services as needed.
2. Careful attention should be made to children entering custody on medications, particularly psychotropic medications. If there are any questions pertaining to the child's medications, the case manager will contact the Regional Health Advocacy Unit Nurse for consultation.

H. Permanency plan

EPSDT screenings must be incorporated into the Permanency Plan process and must be included in the initial and ongoing treatment plans.

I. Documentation

1. Appropriate staff at youth development centers and community residential facilities must ensure that all components of Sections B, C, D and E are documented in the youth's case file and TN Kids.
2. Case managers responsible for youth and children in DCS foster care or contract agencies, must ensure that EPSDT and laboratory screenings are appropriately documented in case recordings and TN Kids.

Forms/Templates

The forms to be used are in the process of being approved through TennCare and DCS.

Collateral Documents

None

Standards

3JTS-4C-25
3JTS-4C-23
3-JCRF-4C-25

Subject: EPSDT Standards

20.7

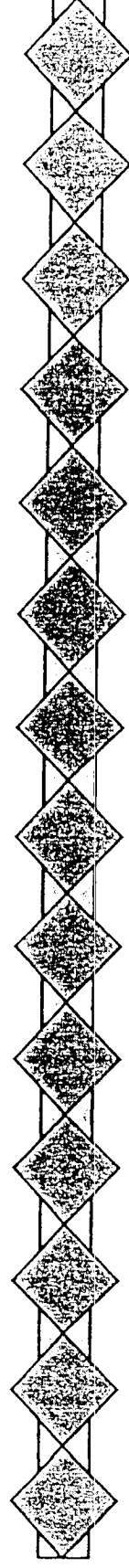
Glossary

<i>Term</i>	<i>Definition</i>
<i>Clinical Practitioner</i>	Physician, physician's assistant, nurse or nurse practitioner.

Attachment G

EPSDT Documentation Pilot Study

EPSDT DOCUMENTATION PILOT



STATUS REPORT
June 13, 2001

EPSDT DOCUMENTATION PILOT



Intervention:

- ◆ “Immediate” bonus payment to PCP for submission of completed Attestation Form
 - ◆ Attestation Form attests to components of EPSDT screen performed and documented
 - ◆ Bonus payment requires claim for 99080 in conjunction with a preventive screening visit code.
-

EPSDT DOCUMENTATION PILOT

BCBST Workflows

ATTESTATION FORM:

- ◆ Receive form by fax or mail
 - ◆ Enter Attestation data into Access database
HCFA 1500 CLAIM:
 - ◆ Pay \$10.00 for 99080 billing
-

EPSDT DOCUMENTATION PILOT



Objective of Region 3 Pilot:

- ◆ Develop and test processes to support administration of EPSDT documentation bonus
 - Claims process
 - Attestation Form process
-

EPSDT DOCUMENTATION PILOT



Pilot Results (Phase I)

- ◆ 147 Attestation Forms received
 - ◆ 87% of components attested to
 - ◆ 95% accuracy Form vs chart
 - ◆ All claims for 99080 (100%) were accompanied by a preventive visit claim
-

EPSDT DOCUMENTATION PILOT



Percent of all components attested to

(# YES for all components / total # of possible Yes X 100)

$$(734 / 106 \times 8)$$

$$(734 / 848 = .87)$$

87%

EPSDT DOCUMENTATION PILOT



Percent of each component attested to

(# YES for single component / total # of cases X 100)

History	97.1%	Behavioral	98.1%
Physical	96.2%	Education	96.2%
Vision	62.2%	Hearing	69%
Lab	85%	Immunizations	92%

PILOT CHART AUDIT



Verification of Documentation

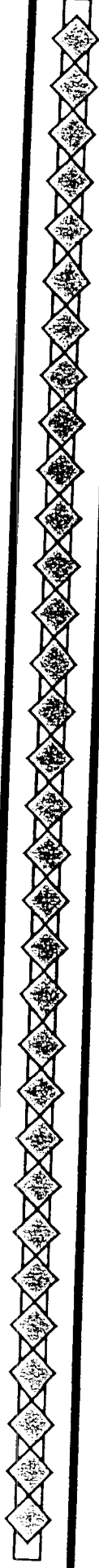
- ◆ 147 Attestation Forms received
 - ◆ 59 Charts randomly selected to audit
(95% CI)
 - ◆ 9 Practitioners audited in 4 Offices
-

PILOT AUDIT RESULTS



- ◆ 472 potential component variances (8 components x 59 charts)
 - ◆ 23 Components form: chart at variance (4.9% variance*)
 - ◆ 449 Components form: chart not at variance (95.1% accuracy)
-

PILOT AUDIT RESULTS



*13 of the 23 variances due to lack of subjective hearing
& vision documentation.

PILOT CLAIMS ANALYSIS



- ◆ All claims for 99080 (100%) were accompanied by a preventive visit claim
 - ◆ 18% of 99080 claims did not have a corresponding Attestation Form.
-

EPSDT DOCUMENTATION PILOT



Conclusions:

- ◆ Feasible to administer
 - ◆ Positive reception by physicians
 - ◆ Timely component-specific data without chart audit
 - ◆ Provider barriers: knowledge, reminder, feedback, reimbursement
-

Attachment H

Draft Best Practice Guidelines for Physical Health Services



BlueCross BlueShield
of Tennessee

An Independent Licensee of the BlueCross BlueShield Association



To: Billy Arant, Jr., MD
Jacqueline Shaw, MD

CC: Larry Faust, MD

From: David Moroney, MD *DM*
Regional Medical Director

Dept: Health Care Services

Floor/Phone: 3G6/755-6346

Date: July 13, 2001

Subject: BPN Medical Guidelines - Draft

Memorandum

The BPN Provider Manual has been approved and will soon be distributed by BlueCross BlueShield of Tennessee (BCBST). The enclosed draft of the BPN Medical Guidelines has been revised to be consistent with the information in the BPN Provider Manual.

Please review and forward comments or questions to Larry Faust. My understanding is that the BPN Medical Guidelines are to be considered for approval at the next meeting of the Steering Panel.

Lisa Turner 755-6367

Assistant to:

David Moroney, MD

Robert Giles, Jr., PharmD

Best Practice Network (BPN) Guidelines

The Best Practice Network (BPN) is a sub-network of TennCareSM Select; the State of Tennessee's self-insured TennCareSM Health Maintenance Organization.

This special sub-network was created by the state for a select population of children who are in state custody or at risk of entering state custody. It is composed of Primary Care Practitioners (PCPs), Dentists and Behavioral Health Providers who have agreed to serve the health care needs of this unique population and to fulfill special roles and responsibilities associated with the management of these children.

These guidelines focus on Medical Home, Chaperones, Confidentiality, Medical Records, EPSDT, Mental Health Screening, and School Issues, and are intended to help Best Practice Network Practitioners provide these children with the health care services they need.

Practitioners in the Best Practice Network are expected to follow general practice guidelines and policies of recognized professional organizations such as The American Academy of Pediatrics and the National Institutes of Health. However, it is recognized that special needs children often have complex medical, behavioral, and social problems that require deviation from general guidelines.

American
Academy of
Pediatrics



Policy Statement

Pediatrics

Volume 90, Number 5

November, 1992, p 774

The Medical Home (RE9262)

AMERICAN ACADEMY OF PEDIATRICS

Ad Hoc Task Force on Definition of the Medical Home

The American Academy of Pediatrics believes that the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family centered, coordinated, and compassionate. It should be delivered or directed by well-trained physicians who are able to manage or facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a relationship of mutual responsibility and trust with them. These characteristics define the "medical home" and describe the care that has traditionally been provided by pediatricians in an office setting. In contrast, care provided through emergency departments, walk-in clinics, and other urgent-care facilities is often less effective and more costly.

We should strive to attain a "medical home" for all of our children. Although geographic barriers, personnel constraints, practice patterns, and economic and social forces make the ideal "medical home" unobtainable for many children, we believe that comprehensive health care of infants, children, and adolescents, wherever delivered, should encompass the following services:

1. Provision of preventive care including, but not restricted to, immunizations, growth and development assessments, appropriate screening, health care supervision, and patient and parental counseling about health and psychosocial issues.
2. Assurance of ambulatory and inpatient care for acute illnesses, 24 hours a day, 7 days a week; during the working day, after hours, on weekends, 52 weeks of the year.
3. Provision of care over an extended period of time to enhance continuity.
4. Identification of the need for subspecialty consultation and referrals and knowing from whom and where these can be obtained. Provision of medical information about the patient to the consultant. Evaluation of the consultant's recommendations, implementation of recommendations that are indicated and appropriate, and interpretation of these to the family.
5. Interaction with school and community agencies to be certain that special health needs of the individual child are addressed.
6. Maintenance of a central record and data base containing all pertinent medical information about the child, including information about hospitalizations. This record should be accessible, but confidentiality must be assured.

Medical care of infants, children, and adolescents must sometimes be provided in locations other than physician's offices. However, unless these locations provide all of the services listed above, they do not meet the definition of a medical home. Other venues for children's care include hospital outpatient clinics, school-based and school-linked clinics, community health centers, health department clinics, and others. However, wherever given, medical care coverage must be constantly available. It should be supervised by physicians well-trained in primary pediatric medicine, preferably pediatricians. Whenever possible, the physician should be physically present where the care is provided; but it may be necessary for the physician to direct other health care providers such

as nurses, nurse practitioners, and physician assistants off site. Whether physically present or not, the physician must act as the child's advocate and assume control and ultimate responsibility for the care that is provided.

AD HOC TASK FORCE ON DEFINITION OF THE MEDICAL HOME

Michael D. Dickens, MD

John L. Green, MD

Alan E. Kohrt, MD

Howard A. Pearson, MD

The Medical Home Statement Addendum: Pediatric Primary Health Care (RE9262)

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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American
Academy of
Pediatrics



Policy Statement

Pediatrics

Volume 98, Number 6

December, 1996, p.1202

The Use of Chaperones During the Physical Examination of the Pediatric Patient (RE9644)

AMERICAN ACADEMY OF PEDIATRICS

Committee on Practice and Ambulatory Medicine

ABSTRACT. The intent of this statement is to inform practitioners about the purpose and scope of an appropriate physical examination for children, adolescents, and young adults, and the need to communicate this information to the parents and the patient. Issues of patient comfort, confidentiality, and the use of a chaperone are addressed. An appropriate physical examination should result in efficient, sensitive, and effective health care.

An appropriate physical examination is often a critical component of a visit to the pediatrician by a child, adolescent, or young adult. There are multiple goals of the physical examination, including detection of developmental delays and/or physical abnormalities, which may be congenital or acquired, and detection of clues to the cause of a current illness. The extent of the examination is determined by both the reason for the visit and by diagnostic considerations raised during the history taking. Some physical examinations will be highly focused and the child, adolescent, or young adult will be fully clothed. At other times, during a physical examination, the patient may be partially or completely unclothed. In these cases an appropriate gown should be provided.

The purpose and scope of the physical examination should be made clear to the parents. It should also be made clear to the patient if he or she is old enough to understand. If any part of the examination will be physically or psychologically uncomfortable, the parents and patient should be so informed in advance of the examination. Similarly, the pediatrician must be sensitive to the patient's and parent's feelings about an examination, particularly if the breasts, ano-rectal area, and/or genitalia require inspection or palpation. In some cases, either the patient, the parent, the pediatrician, or some combination of these persons may wish to have a chaperone present. In those cases, the chaperone protects the interest of the patient and the pediatrician. However, there are a variety of circumstances, including those in which the patient requests confidentiality, that would render the presence of a chaperone problematic. Physician judgment and discretion must be paramount in evaluating the needs for a chaperone; however, the highest priority should be given to the requests of the patient and the parent. If a patient is offered and declines the use of a chaperone, the pediatrician should document this fact in the chart. Communication in advance regarding the components of the physical examination being performed is of critical importance in any event.

Attention to these principles should result in more efficient, sensitive, and effective health care for children, adolescents, and young adults while preventing misunderstandings about the reasons for and conduct of the examination.

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The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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Confidentiality, Informed Consent and Medical Records

Best Practice Network Providers face several issues concerning confidentiality, sharing of records and informed consent when treating BPN Members. These issues are inter-related due to the involvement of various agencies and the multidisciplinary care that these children require.

The following guidelines are compilations of DCS and TennCareSM rules and regulations; American Academy of Pediatrics (AAP), Tennessee Medical Association (TMA), and American Medical Association (AMA) opinions; the Tennessee Code Annotated Title 33 and Federal Regulations Title 42 regarding confidentiality of records and consent. They are intended to aid PCPs in addressing concerns, but it is understood that the complex nature of this population of children make it impossible to address all scenarios.

A. Confidentiality and Informed Consent

1. A physician may perform emergency medical or surgical treatment on a minor despite the absence of parental consent or court order if the physician has good faith belief that delay in care would result in worsening of the medical condition and the provision of such care would further deterioration of the condition.
2. By case law in Tennessee, the common law Rule of Sevens applies to minors. A child age 14 through 17 is presumed to be competent to seek their own medical care without the knowledge and consent of their parents or legal custodians. The child must be counseled to determine that the child actually is competent, and the record must reflect such determination by the caregiver. Release of medical records of such an individual age 14 through 17 must be signed by the child and cannot be given to the parent or custodian without such release. If it is determined that the child is incompetent, the services should not be provided without consent of the legal guardian or parent.

A child 7 through 13 is presumed to be incompetent to seek their own medical care. However, if counseling of the child shows the child is competent, the medical services may be provided. The child's medical record must reflect such counseling and determination.

A child under the age of 7 is incompetent to seek his/her own medical care, and no care can be provided without the consent of the parent or custodian. The Physician should encourage the minor to involve the DCS worker, foster parent, or guardian, but should respect the wishes of the minor in aspects of confidentiality.

Specific examples include:

- a. Physicians may treat juvenile drug abuses without prior guardian consent. Physicians should use their own discretion in determining whether to notify the child's guardian.
- b. A Physician may diagnose, examine, and treat a minor without knowledge or consent of the legal guardian for purposes of providing prenatal care.
- c. Contraceptive supplies and information may be supplied to a minor without consent of the legal guardian.
- d. The Physician may diagnose and treat STDs without the knowledge or consent of the parent or guardian. Legal reporting requirements to the Department of Health still exist.
- e. Confidentiality may be breached in situations where necessary to avert harm; e.g., threat of suicide or bodily harm to other individuals or situation in which the child's behavior places him/her at significant risk.

B. Medical Records

1. The following individuals may request and receive copies of the child's medical records:
 - a. The custodian of a minor. Either parent (whether custodial or not) can request a copy of the child's records, unless parental rights have been terminated by a court the child's consent as per Rule of Sevens applies.
 - b. For mental health records, a juvenile 16 years of age or older.
 - c. A court having jurisdiction over the child.
 - d. In cases where parent or guardian has been accused of abuse of the child, the records may be withheld from that individual. In addition, record release may be withheld, if a Physician feels that making a record available to an individual would jeopardize a child's well being. When release of medical information is not in the best interest of the child, the PCP should immediately contact the DCS caseworker that can contact the juvenile judge to direct limitations to the release of records.
2. The federal law addressing school records is the Family Rights and Privacy Act (FERPA). Exceptions to requiring parental consent for disclosure include a school official with legitimate educational interests, and this is further defined as including a medical consultant. However, it is recommended that the PCP work with the DCS case manager to assure that all non-medical providers, such as the school system, receive a release of information form and assure that the PCP also has a reciprocal form to share information with the school or other community agencies involved in the child's care.
3. A DCS case manager, biological parent (unless rights have been terminated by a court), or the foster parent can accompany the child to the office and can consent to treatment. DCS should provide twenty-four hours, seven-days-a-week availability to the PCP of an authorized representative able to sign on behalf of the child to cover situations when the above mentioned are not available.
4. When a child sees another Provider on a referral, a Release of Information form should accompany the child.
5. Any information received by the PCP from other health care Providers shall become part of the PCP's chart and may be shared along with any other information in the child's record. Likewise, any information the PCP provides to another Physician shall become part of the record of that Physician.

C. BPN PCP Medical Record Update Form

A *BPN PCP Medical Record Update* form has been developed to ensure details of health services provided to BPN Members may be forwarded to the PCP in a condensed, manageable form for the PCP review and inclusion in the Member's medical record. When services are rendered to a BPN Member, the provider rendering the service should communicate the information related to the encounter to the BPN PCP either through the *BPN Medical Record Update* form or via a letter, which contains all the information requested on the form.

D. BPN PCP Medical Record Audit

VSHP is required to perform a comprehensive medical record audit on BPN Member records two (2) times over the eighteen-month period running from July 1, 2001, through December 31, 2001. Special attention will be focused on EPSDT compliance since entering the BPN and evidence of completeness of the medical record, inclusive of communication from referral specialists through the BPN PCP Medical Record Update form or a letter, which contains all the information on the form.

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Policy Statement

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Privacy Protection of Health Information: Patient Rights and Pediatrician Responsibilities (RE9927)

AMERICAN ACADEMY OF PEDIATRICS

Pediatric Practice Action Group and Task Force on Medical Informatics

ABSTRACT. Pediatricians and pediatric medical and surgical subspecialists should know their legal responsibilities to protect the privacy of identifiable patient health information. Although paper and electronic medical records have the same privacy standards, health data that are stored or transmitted electronically are vulnerable to unique security breaches. This statement describes the privacy and confidentiality needs and rights of pediatric patients and suggests appropriate security strategies to deter unauthorized access and inappropriate use of patient data. Limitations to physician liability are discussed for transferred data. Any new standards for patient privacy and confidentiality must balance the health needs of the community and the rights of the patient without compromising the ability of pediatricians to provide quality care.

ABBREVIATIONS. HIPAA, Health Insurance Portability and Accountability Act of 1996; IRB, institutional review board; EDI, electronic data interchange; UPI, unique patient identification (number).

Pediatricians or their affiliated institutions are responsible for the security and confidentiality of medical records in their possession. Federal and state legislation has been enacted to regulate the privacy and protection of these records.¹ Currently more than 40 states have statutes imposing civil or criminal penalties for impermissible disclosure of medical information.²

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)³ authorizes the federal government to establish a national standard for medical record privacy either by legislative or regulatory action. Such federal standards are important, and care should be taken to balance the needs of society to advance public health and individual rights to privacy. The benefits to a community that may result from clinical and outcomes research, enforcement of health regulations, and risk management audits based on data harvested from patient records must be weighed against the risks of unauthorized access to individual health data. The American Academy of Pediatrics recommends that legislated or regulated provisions accommodate the unique needs of pediatric patients--newborns, infants, children, adolescents, and young adults. Furthermore, the American Academy of Pediatrics urges that legislated or regulated standards also address security requirements for electronic data transmission of health information.

These requirements should be reasonable and appropriate for the technology used to store, update, and transmit data. Most importantly, the security provisions should not unduly burden physicians or impede the provision of health care. The ability to transmit data electronically and the emergence of computerized medical records raise new issues about the responsibility of pediatricians transmitting patient-specific information.⁴

Although the principles of privacy protection apply equally to paper and electronic records, electronic

data files are disseminated more easily than paper records and therefore may be more easily subject to unintended use. For example, data that include patient identification may be transmitted electronically to personnel of a health insurance payer to facilitate claim adjudication for reimbursement. Health insurers may also be required to use these data to comply with regulating organizations such as the National Committee for Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS) measurements. However, these data can also be used to link a diagnosis code or demographic data to other clinical data or laboratory results. Data that disclose health conditions potentially associated with high financial costs may be used to discriminate unfairly against patients. Misuse of patient information for purposes unintended by the patient or pediatrician or not delineated in the providers' contractual documentation violates the right to privacy of patients.

Pediatricians or their affiliated institutions are obligated to protect the confidentiality of all patient medical records. Protection can be achieved by implementing security policies to control access to patient records, requiring appropriate authorization before releasing health data, and providing additional security measures to more sensitive data.

PRIMARY AND SECONDARY USES OF HEALTH DATA

Decisions to monitor, restrict, or control access to individual medical records may be evaluated by determining whether those accessing information are primary or secondary users of health information.⁵ Primary users are clinicians (physicians, nurses, nursing assistants, therapists, and other allied health professionals) who need access to patient information to provide appropriate health care to the patient. At least one state has enacted legislation prohibiting the transfer of maternal health information to the child's hospital nursery. The restrictions on providing information may put the health of the newborn at risk by not allowing essential maternal history to be available to the newborn's clinicians.

Secondary users of health data include researchers, educators, third-party payers, business administrators, legal representatives, auditors, employers, public health officials, and quality assurance and utilization review staff who may or may not also be clinicians. The secondary users' need for access to health data may be unrelated to the patient's treatment. Patients have a right to be notified of the individuals, organizations, and government agencies that have authority to access or receive data from their medical records. Health insurers or payers who require access to patient records as part of their ongoing quality improvement program or utilization review should be required to notify insured patients of this requirement. Disclosures about the need to review or excerpt patient data should specify whether these aggregate data or data that identify individuals are analyzed and for what purpose. If traceable patient data are used, secondary users should be required to abide by federal security provisions to protect patient confidentiality.

ACCESS TO MEDICAL RECORDS

Medical records are the property of the institution at which they were created, but patients generally have certain rights to the information contained in the records, which vary from state to state.⁶ Pediatricians and their patients (and/or custodial parents) decide who may have limited or comprehensive access to information contained in the medical records. Generally, custodial parents are entitled to review their children's medical record at any time, except for emancipated minors or minors with other specific rights to confidentiality. Pediatricians have a crucial role in mediating discussions between parents and adolescents to minimize conflicts over access to this information. Preadolescents and adolescents may also have other rights to confidentiality and may limit access to their medical records based on their age, the nature of their diagnosis, or other factors delineated by state or federal law.^{6,7} These rights must be recognized and protected by all parties with access to the patient's medical record and should not be diminished by federally mandated standards for privacy of health information.

Patients (and/or custodial parents) should be aware of the risks associated with authorizing the release of health information for purposes unrelated to patient treatment and consider the following:

- the sensitivity of the information,
- whether the data have been requested by a primary or secondary user,
- the stated use for the data,
- whether limited or complete access to patient data has been requested,
- whether the data identify patients or are blinded, and
- whether the data are analyzed and reported as independent or combined with other patient information and analyzed and reported as aggregate.

The Institute of Medicine has delineated three levels of security based on the nature of the specific health information in a patient record: nonprivileged (least sensitive), privileged (sensitive and traditionally confidential), and deniable (extremely sensitive and confidential).⁸ Electronic security tools such as electronic signatures, passwords, encryption, patient identifiers, clinician authentication, and audit trails may permit graduated levels of security, with extremely sensitive information receiving the most security protection. Required data collection and reporting to secondary users, however, may make it difficult to protect sensitive information about sexually transmitted diseases,⁹ adoption,¹⁰⁻¹² physical abuse,¹³ substance abuse,^{14,15} human immunodeficiency virus infection,^{16,17} sexuality,¹⁸⁻²¹ genetic disorders, cancer, and mental health. Health information that is divided to permit only limited access to or selective release of required data may afford additional security, such as the use of separate sections (in paper-based medical records) or password protected data fields (in electronic medical records).

MEDICAL RECORD RELEASE FORMS

Patients should not be required to give unconditional release of their medical records to unknown sources. Unlimited permission may expose patient records to inappropriate use of the medical information. In group practices, in practices owned by corporate entities, and for the purpose of obtaining consultation, clinicians may share medical information as needed to provide treatment. Clinical and administrative staff need to understand the limitations of their access to patient information and their responsibility to protect the patient's right to privacy. Pediatricians or their affiliated institutions should enforce disciplinary action for inappropriate access to or disclosure of patient health information by clinical or administrative staff. Signed release forms should be obtained to document authorized releases of health information. Pediatricians or their affiliated institution should keep all original medical record documents. Anonymous patient information and data to be used for medical education, research, or public health functions should be accessible under standard protocols monitored by appropriate bodies, such as institutional review boards (IRBs).²² There may be situations, however, in which researchers need access to medical records that identify patients' records only accessible by entities under the purview of an IRB with appropriate security to protect the patient's privacy. Specific statutes may mandate disclosure without informed consent, as in cases of child abuse.²³ In the absence of appropriate IRB approval of access to medical records for research purposes, the individual medical record should only be accessed or transferred with the informed consent of the patient (and/or custodial parents).²⁴

ACCURACY AND INTEGRITY OF MEDICAL RECORDS

Pediatricians or their affiliated institutions are responsible for the accuracy and integrity of their medical records. Information contained in medical records should be accurate, objective, legible, timely, and comprehensive. Once an entry is made into the medical record, it should never be deleted.²⁵ If it is later determined that specific information in an entry is incorrect, it may be changed by the clinician as long as the original entry remains legible and the corrected entry is clearly marked.

dated, and initialed. Changes made to electronic medical records are done more easily and may be more difficult to discern. Clinicians using electronic information systems should verify that security protocols are in place to ensure against unauthorized changes or attempts to modify the electronic record. With the same procedure as that used by clinicians, patients (and/or custodial parents) also may append written comments to the medical record.

ELECTRONIC TRANSMISSION OF HEALTH DATA

Pediatricians should use reasonable security practices to safeguard the confidentiality of patient data when patient records are transmitted electronically, whether by facsimile, electronic mail, the Internet, or other channels. Ideally, patient information transmitted electronically should be sent to a specific person who agrees to be responsible for the information once it is received. Health information should not be transmitted to an unidentified receiving station. To maintain confidentiality, use of cover sheets with privacy disclaimers and requests for return receipts for transmitted data are appropriate and prudent strategies. Software products are available to encrypt sensitive medical information and may improve the security of the transmission. Once the transmission of the medical record has occurred, federal regulations should mandate that the privacy of the health information is the responsibility of the receiving party and that the information is used exclusively for those purposes stated in obtaining the record. Informed consent from the patient must be obtained to use the information for any other purpose.

ELECTRONIC BILLING

The shift from paper-based accounting to electronic billing and reimbursement with federally mandated uniform format requirements may prompt clinicians to use outside sources for certain electronic data interchange (EDI) functions. These EDI clearinghouses or value added networks receive electronic transmissions from an affiliated institution (for example, a physician office or pediatric clinic), translate the data into the required electronic format, and transmit the data electronically to the payer. EDI vendors should be accredited to ensure that their data security systems meet the federal standards for patient privacy and security. Under current HIPAA regulations, penalties of \$100 per violation, not to exceed \$25 000 per person per year, may be imposed for failing to comply with these standards. Consequently, institutions that have used an accredited EDI vendor should not be liable for vendor errors. Federal standards for electronic transmissions supersede state law unless the state receives a waiver from the Secretary of Health and Human Services. State Medicaid programs should be required to comply with federal EDI standards.

HEALTH REGISTRIES

The development of health registries indicates that certain elements of an individual's medical record may need to be accessible by the public.²⁶ Health registries are organized systems for collecting, storing, retrieving, analyzing, or disseminating information on individuals with a particular disease, risk factors, or exposures to a substance or circumstance known to cause adverse health effects. Registries may be operated by federal government agencies (eg, the National Exposure Registry), universities (eg, Surveillance, Epidemiology and End Results, a cancer registry), nonprofit organizations (eg, United States Eye Injury Registry), private groups (eg, transplant registries), or state governments (eg, electronic birth registries, newborn laboratory screening systems, and immunization registries). Plans for implementing a unique patient identification (UPI) number as part of the HIPAA administrative simplification provisions were stopped when it was perceived that the establishment of the UPI could create a national health databank. This raised concerns regarding patient privacy and medical record confidentiality. The federal government decided to halt development of the UPI standard until federal statutes or regulations protecting the privacy of health information are in place.

More than 20 states have begun to establish immunization registries and many others are considering legislative proposals to authorize them. Such public health measures are intended to protect the

community from outbreaks of vaccine-preventable diseases, to assess the cost-effectiveness of care, and to simplify the reporting of data to state health agencies or local schools. However, without appropriate security protections and prospective patient authorization to release immunization data, vaccine registries may contribute to the erosion of privacy of patient health information. California has recently enacted legislation granting health care professionals access to immunization databases without the patient's consent. When the benefits to the public outweigh the need for patient privacy, pediatricians may choose to support such a program²⁷ but should ensure that potential liability risks associated with releasing patient data to a registry are minimized. Before collection of immunization registry data commences, adequate privacy protections need to be in place, including restricted access to data entry, update, review and release; strict penalties for unauthorized disclosure; and protection of the registry system from court order or subpoena. The registry staff should provide written policies describing the privacy and security standards, which should be disseminated to registry employees, immunization providers, patients, and parents. These policies should explain the purposes for which the data are to be used, the parties that will be allowed to input and receive data, and the requirement for written authorization before any data are released for purposes not intended by registry policies and regulations.

Pediatricians need to protect the information in their patients' medical records. Federal requirements supersede less protective state laws and no existing rights to privacy presently afforded to patients, particularly to minors, should be expunged, limited, or restricted by new federal privacy standards. HIPAA legislation does not intend to reduce the privacy protections currently afforded pediatric patients.

RECOMMENDATIONS

1. Pediatricians should understand and abide by legislative and regulatory requirements that address the confidentiality, secure transmission and storage, and public accessibility of patient medical information.
2. Pediatricians or their affiliated institutions should accept the responsibility for protecting the confidentiality of their medical records by personnel education, office procedures, and security strategies that are in compliance with federal standards.
3. Pediatricians should advocate for the ability to access medical information for properly regulated medical education, research, and public health functions that undergo periodic and systematic review of their appropriateness and that comply with applicable patient confidentiality and research regulations.
4. Pediatricians should urge policy makers to weigh the administrative burdens and risks to patient confidentiality against the projected benefits to be derived from medical data being collected, protected, analyzed, or disseminated either publicly or privately.
5. Pediatricians should support legislation to require payers to notify their insured at least annually whether the payers may review their medical records. Such notification should identify the reviewers and the data, and purposes (for example, continuous quality improvement, review of claims, or accreditation) for which the data are to be used.
6. Patients (and/or custodial parents) should be advised of the risks associated with signing unconditional releases for their health information.
7. Patients (and/or custodial parents) should know their rights to keep their medical information confidential. Insurers should be required to inform them of the consequences to their insurance coverage should they refuse the insurer access to medical information. Patients should be notified of regulatory or legislative requirements that may require outside access to their record.
8. Patients (and/or custodial parents), within the limits of statute, should have the right to review their medical records. They should be permitted to append comments to chart notations that they believe incorrect or incomplete, to authorize the release of health information, and to request in writing a copy of their medical records.
9. Pediatricians or their affiliated institutions have a right to retain original medical records. On receipt of a written request from the patient authorizing the release of their medical record, pediatricians or their affiliated institutions may provide a summary or photocopy of the

complete record and may charge reasonable fees for providing copies.

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The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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Policy Statement

Pediatrics

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Consent for Medical Services for Children and Adolescents (RE9309)

AMERICAN ACADEMY OF PEDIATRICS

Committee on Pediatric Emergency Medicine

Major societal changes affecting the provision of child health care have occurred over the last few decades. In the area of emergency services, consent for medical treatment is an important issue. The purpose of this statement is to outline major considerations involving consent and provide the physician with practical guidelines concerning this issue.

Today fewer than one third of children live in two-parent families in which only the father works outside the home. [1,2] Because of foster care placement, or temporary or permanent arrangements with relatives or friends, parents may not be available to give consent for treatment of their children. [3-6]

Unaccompanied minors may seek medical attention in any one of a number of locations. Some go to the emergency department, 14% of which have no policy regarding consent for the care of these patients. [7] Unaccompanied minors younger than 18 years of age account for 3.4% of all emergency department visits. [7] Twenty-two states and the District of Columbia now have laws concerning the "mature minor." Most other states have provisions in which competent minors may arrange for care involving contraceptives, pregnancy, abortion, sexually transmitted diseases, drug and alcohol abuse, and psychiatric disorders. [8]

The dilemma for emergency physicians and practicing pediatricians alike is whether to follow a strict interpretation of the law or to adopt a more practical approach. Clearly, consent is not required in life- or limb-threatening emergencies, [8,9] although the definition of emergency varies from state to state. However, in most instances, only routine care, not emergency care, is needed. As a result, many physicians fear charges of battery or litigation should their judgment regarding treatment be questioned. [8] In support of a common sense approach to treatment, [10] Holder noted that in a review of 30 years of emergency medical care, lack of consent was not the basis for a judgment against the physician. [11] Legal definitions aside, the overwhelming sentiment is that physicians should be guided by an approach that is in the best interest of the patient.

To provide expedient care for children in an ethical, legal, and reasonable manner in emergency departments or in other situations where nonelective medical treatment is given, the American Academy of Pediatrics (AAP) makes the following recommendations:

1. Pediatricians would be well served to become familiar with their state and local laws and institutional policies regarding consent and the definition of emergency. Several authors have summarized current state laws and provisions for care of unaccompanied minors. [12,13] State or local medical societies may be consulted for information or for copies of state or jurisdiction statutes. AAP state chapters may wish to take an active role in informing their membership of existing statutes in their state regarding consent, the mature minor doctrine, and the definition of emergency.
2. Emergency departments and clinics should develop practical written guidelines regarding consent.

These policies should be based on the nature of the practice and local or state law. Pediatricians should consider whether they need such guidelines for their office.

3. When another adult is acting in place of a parent for a child (in loco parentis), the physician should document the situation in the medical record, including attempts to obtain verbal or written consent from a parent.
4. Physicians in primary care settings might assist parents by providing them information regarding the need to provide written consent for nonelective medical treatment for their child when unavailability can be anticipated, including times when the child is in child care, left with friends or relatives, at school or camp, or with noncustodial relatives.
5. Pediatricians should encourage parents to become familiar with child care, school, and other institutional policies.
6. Parents should provide child care centers, schools, or other caretakers with the following information: how they can be reached if medical care becomes necessary; basic information about the child's health care record, including immunizations, allergies, medications, and chronic illnesses; and preferences for a physician or facility for treatment. Written consent should be provided.
7. Parents should be certain their children know their home address, phone number, and the name of their parents' workplaces. In appropriate situations, physicians should discuss with parents, and with internal hospital disaster committees, methods of identifying children (eg, shoestring tags or arm bands) in the event of a mass casualty disaster.
8. Schools should be urged to follow the guidelines outlined in the AAP policy statement "Guidelines for Urgent Care in School." [14] Among other important issues, this statement suggests the following: (1) every school district should identify individuals who are authorized and trained to make urgent medical care decisions; (2) parents should be informed about injuries their children receive at school as quickly as possible; (3) if a parent or legal guardian cannot be reached, the name and telephone number of an individual to be contacted in case of emergency should be readily available; and (4) a description of illnesses or injuries of a serious nature (those illnesses or injuries in which a student or visitor is released from school to see a physician or to be seen at a hospital) should be recorded on an illness and accident form according to predetermined district procedures.
9. Barriers to effective medical care of children should be removed. No evaluation of a life-threatening or emergency condition of a child should be delayed because of a perceived problem with consent or payment authorization. Decisions regarding the emergent nature of treatment should be made on the basis of that evaluation.
10. Social service or other governmental agencies should have given or be available to provide consent for children in foster care. Model legislation should be developed giving foster parents, noncustodial parents, and other surrogates the authority to give consent for emergency medical care. Such legislation might include the following statement and conditions:

The act of leaving a child with a custodian by the parent or the state represents implied consent in situations where the parent is not immediately available for verbal consent, and nonelective medical care is needed. These situations might include, but are not limited to, the following conditions:

- * Relief of pain or suffering
- * Suspected serious infectious disease
- * Assessment and treatment of serious injury
- * Life-, limb-, or central nervous system-threatening conditions.

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American
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Policy Statement

Pediatrics

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Informed Consent, Parental Permission, and Assent in Pediatric Practice (RE9510)

AMERICAN ACADEMY OF PEDIATRICS

Committee on Bioethics

The statement on informed consent, parental permission, and patient assent has a long and extraordinary history. The first draft of this document, prepared by William G. Bartholome, MD, was presented to the original American Academy of Pediatrics (AAP) Committee on Bioethics in 1985. Bill put his soul into the manuscript and has watched over it carefully ever since. Now, a decade later, those who have worked on its continued development and urged its adoption as Academy policy applaud its publication. No one is more gratified than its primary author and champion. Those who have had the privilege to know Dr Bartholome share his sense of accomplishment, but cannot help but experience a cruel sense of irony. Just as the work Bill considers his most important contribution has become available for public appreciation, Dr Bartholome suffers from a serious illness that threatens his life.

Bill always wanted "the experience, perspective, and power of children" to be taken most seriously. Through the years of the statement's revisions and re-presentation within the Academy, Bill "had faith in the power of the text and the ideas it contained, ... that its time would come." The statement embodies Bill Bartholome's dedication to children. Throughout his career, he worked to make medicine and medical research safer and more friendly for children. The AAP and its Committee on Bioethics, on behalf of all our colleagues, extend heartfelt thanks to Dr William G. Bartholome for helping us more fully appreciate that children are in the process of becoming, in his words, "intelligent, observant, capable, and responsible persons" who deserve our utmost respect.

AN OVERVIEW

Since the 1976 publication of an AAP policy statement on the legal concept of informed consent in pediatric practice, the concept has evolved and become more formal.[1] A better understanding now exists as to how physicians should collaborate with patients and parents in making these decisions. Patients should participate in decision-making commensurate with their development; they should provide assent to care whenever reasonable. Parents and physicians should not exclude children and adolescents from decision-making without persuasive reasons. Indeed, some patients have specific legal entitlements to either consent or to refuse medical intervention. Although physicians should seek parental permission in most situations, they must focus on the goal of providing appropriate care and be prepared to seek legal intervention when parental refusal places the patient at clear and substantial risk.[2] In cases of serious conflict, physicians and families should seek consultative assistance and only in rare circumstances look to judicial determinations.

We now realize that the doctrine of "informed consent" has only limited *direct* application in pediatrics. Only patients who have appropriate decisional capacity and legal empowerment can give their informed consent to medical care. In all other situations, parents or other surrogates provide

informed permission for diagnosis and treatment of children with the assent of the child whenever appropriate.

In this statement, the AAP provides an updated analysis of 1) the concept of informed consent; 2) the ethics of informed consent and the concept of the right to refuse treatment; 3) the concept of "proxy consent"; 4) the concepts of parental permission and child assent; and 5) informed consent of adolescents.

CHANGES IN MEDICAL DECISION-MAKING

The authority to make medical decisions used to lie squarely in the hands of physicians. However, complex social changes have resulted in acceptance of the idea that patients have a right to know about their health, to know about available diagnostic and treatment options and their risks and probable benefits, and to choose among the alternatives.[3] Many now regard traditional practices based on the theory that "doctor knows best" as unacceptably paternalistic.[4] Society recognizes that patients or their surrogates have a right to decide, in consultation with their physicians, which proposed medical interventions they will or will not accept. Decision-making power or authority is increasingly seen as something to be shared by equal partners in the physician-patient or physician-surrogate relationship. For many patients and family members, personal values affect health care decisions, and physicians have a duty to respect the autonomy, rights, and preferences of their patients and their surrogates.[5]

ETHICS AND INFORMED CONSENT

The doctrine of informed consent reminds us to respect persons by fully and accurately providing information relevant to exercising their decision-making rights. Experts on informed consent include at least the following elements in their discussions of the concept:[6]

1. Provision of information: patients should have explanations, in understandable language, of the nature of the ailment or condition; the nature of proposed diagnostic steps and/or treatment(s) and the probability of their success; the existence and nature of the risks involved; and the existence, potential benefits, and risks of recommended alternative treatments (including the choice of no treatment).
2. Assessment of the patient's understanding of the above information.
3. Assessment, if only tacit, of the capacity of the patient or surrogate to make the necessary decision(s).
4. Assurance, insofar as is possible, that the patient has the freedom to choose among the medical alternatives without coercion or manipulation.

The goals of this consent process include the development of the patient's comprehensive understanding of the clinical situation, and the timely exercise, by the patient, of active choices regarding the circumstances.[7,8]

INFORMED CONSENT AND THE RIGHT TO REFUSE TREATMENT

Health care providers should engage in the process of informed consent with patients before undertaking any medical intervention. Patients generally have a moral and legal right to refuse proposed medical intervention, except when the patient has diminished decision-making capacity or must undergo legally authorized "involuntary" treatment. Respect for competent patients' autonomy ordinarily extends even to the refusal or discontinuation of their own life-sustaining treatment.[9]

PROBLEMS WITH THE CONCEPT OF "CONSENT" BY PROXY

In attempting to adapt the concept of informed consent to pediatrics, many believe that the child's parents or guardians have the authority or "right" to give consent by proxy. Most parents seek to safeguard the welfare and best interests of their children with regard to health care, and as a result proxy consent has seemed to work reasonably well.

However, the concept encompasses many ambiguities. Consent embodies judgments about proposed interventions and, more importantly, consent (literally "to feel or sense with") expresses something for one's self: a person who consents responds based on unique personal beliefs, values, and goals.

Thus "proxy consent" poses serious problems for pediatric health care providers. Such providers have legal and ethical duties to their child patients to render competent medical care based on what the patient needs, not what someone else expresses. Although impasses regarding the interests of minors and the expressed wishes of their parents or guardians are rare, the pediatrician's responsibilities to his or her patient exist independent of parental desires or proxy consent.[10]

PARENTAL PERMISSION AND SHARED RESPONSIBILITY

Decision-making involving the health care of young patients should flow from responsibility shared by physicians and parents. Practitioners should seek the informed permission of parents before medical interventions (except in emergencies when parents cannot be contacted). The informed permission of parents includes all of the elements of standard informed consent, as outlined previously.

Usually, parental permission articulates what most agree represents the "best interests of the child." However, the Academy acknowledges that this standard of decision-making does not always prove easy to define. In a pluralistic society, one can find many religious, social, cultural, and philosophic positions on what constitutes acceptable child rearing and child welfare. The law generally provides parents with wide discretionary authority in raising their children.[11] Nonetheless, the need for child abuse and neglect laws and procedures makes it clear that parents sometimes breach their obligations toward their children. Providers of care and services to children have to carefully justify the invasion of privacy and psychologic disruption that come with taking legal steps to override parental prerogatives.

THE DEVELOPMENT OF THE CHILD AS PERSON AND THE CONCEPT OF ASSENT

Decision-making involving the health care of older children and adolescents should include, to the greatest extent feasible, the **assent of the patient** as well as the participation of the parents and the physician. Pediatricians should not necessarily treat children as rational, autonomous decision makers, but they should give serious consideration to each patient's developing capacities for participating in decision-making, including rationality and autonomy. If physicians recognize the importance of **assent**, they empower children to the extent of their capacity.[12] Even in situations in which one should not and does not solicit the agreement or opinion of patients, involving them in discussions about their health care may foster trust and a better physician-patient relationship, and perhaps improve long-term health outcomes.

Assent should include at least the following elements:

1. Helping the patient achieve a developmentally appropriate awareness of the nature of his or her condition.
2. Telling the patient what he or she can expect with tests and treatment(s).
3. Making a clinical assessment of the patient's understanding of the situation and the factors influencing how he or she is responding (including whether there is inappropriate pressure to accept testing or therapy).
4. Soliciting an expression of the patient's willingness to accept the proposed care. Regarding this final point, we note that no one should solicit a patient's views without intending to weigh them

seriously. In situations in which the patient will have to receive medical care despite his or her objection, the patient should be told that fact and should not be deceived.

As children develop, they should gradually become the primary guardians of personal health and the primary partners in medical decision-making, assuming responsibility from their parents.

Just as is the case with informed consent, the emphasis on obtaining assent should be on the interactive process in which information and values are shared and joint decisions are made. The Academy does not in any way recommend the development of new bureaucratic mechanisms, such as "assent forms," which could never substitute for the relational aspects of consent or assent.

THE PATIENT'S REFUSAL TO ASSENT (DISSENT)

There are clinical situations in which a persistent refusal to assent (ie, dissent) may be ethically binding.[13] This seems most obvious in the context of research (particularly that which has no potential to directly benefit the patient).[14] A patient's reluctance or refusal to assent should also carry considerable weight when the proposed intervention is not essential to his or her welfare and/or can be deferred without substantial risk.

Medical personnel should respect the wishes of patients who withhold or temporarily refuse assent in order to gain a better understanding of their situation or to come to terms with fears or other concerns regarding proposed care. Coercion in diagnosis or treatment is a last resort.[15]

ETHICAL CONFLICT AND ITS RESOLUTION

Social forces tend to concentrate authority for health care decisions in the hands of physicians and parents and this tendency diminishes the moral status of children.[12] Thus, those who care for children need to provide for measures to solicit assent and to attend to possible abuses of "raw" power over children when ethical conflicts occur. This is particularly important regarding the initiation, withholding, or withdrawing of life-sustaining treatment.[16,17] Examples of mechanisms to resolve ethical conflicts include additional medical consultation(s); short-term counseling or psychiatric consultation for patient and/or family; "case management" or similar multidisciplinary conference(s); and/or consultation with individuals trained in clinical ethics or a hospital-based ethics committee. In rare cases of refractory disagreement, formal legal adjudication may be necessary.

LEGAL EMANCIPATION AND INFORMED CONSENT

The traditional notion of informed consent clearly applies to patients who have reached the legal age of majority, except when the patient has been determined to be incompetent. In addition, laws designate two settings in which minors have sole authority to make health care decisions.[11] First, certain minors are deemed "emancipated" and treated as adults for all purposes. Definitions of the emancipated minor include those who are: 1) self-supporting and/or not living at home; 2) married; 3) pregnant or a parent; 4) in the military; or 5) declared to be emancipated by a court. Second, many states give decision-making authority (without the need for parental involvement) to some minors who are otherwise unemancipated but who have decision-making capacity ("mature minors") or who are seeking treatment for certain medical conditions, such as sexually transmitted diseases, pregnancy, and drug or alcohol abuse.[18] The situations in which minors are deemed to be totally or partially emancipated are defined by statute and case law and may vary from state to state.[19] Legal emancipation recognizes a special status (eg, independent living) or serious public and/or individual health problems that might not otherwise receive appropriate attention (eg, sexually transmitted disease).

PRACTICAL APPLICATIONS

The following illustrations may help practitioners when applying the concepts developed above. These examples are intended to provide a focus for discussion and clarification and do not suggest new legal standards for pediatric practice.

In cases involving the following kinds of medical care for infants and young children, the Academy encourages physicians to seek the **informed permission of the parents** before: 1) providing immunizations; 2) performing invasive diagnostic testing for a congenital cardiac defect; 3) beginning long-term anticonvulsant therapy to control a seizure disorder; 4) initiating serial casting to correct congenital "clubfoot"; or 5) undertaking surgical removal of a "suspicious" neck mass.

Even in pressing situations, informed permission should be sought for actions such as performing a lumbar puncture to evaluate the possibility of meningitis. (In this situation, if parents deny permission for the procedure, one should obtain permission from the parents to initiate treatment based on reasonable clinical judgment, rather than delaying care or risking liability for performing the lumbar puncture without appropriate authorization).

In cases involving the following kinds of medical care for older school-age children, the Academy encourages physicians to seek the **assent of the patient** as well as the **informed permission of the parents**: 1) venipuncture for a diagnostic study in a nine-year-old; 2) diagnostic testing for recurrent abdominal pain in a 10-year-old; 3) psychotropic medication to control an attention-deficit disorder in a third grader; 4) an orthopedic device to manage scoliosis in an 11-year-old; 5) an "alarm" system to treat nocturnal enuresis in an eight-year-old; or 6) surgical repair of a malformed ear in a 12-year-old. In some cases, treatment may proceed over the objection of the patient. However, physicians and parents should realize that overruling the child may undermine their relationship(s) with the child.

In situations such as the following that involve adolescents and young adults, the Academy encourages physicians to obtain the **informed consent** of the patient, in most instances: 1) performance of a pelvic examination in a 16-year-old; 2) diagnostic evaluation of recurrent headache in an 18-year-old; 3) a request for oral contraceptives for fertility control in a 17-year-old; 4) proposed long-term oral antibiotics administration for severe acne in a 15-year-old; or 5) surgical intervention for a bone tumor in a 19-year-old. Such patients frequently have decision-making capacity and the legal authority to accept or reject interventions, and, in that event, no additional requirement to obtain **parental permission** exists. However, the Academy encourages parental involvement in such cases, as appropriate.

Review of the limited relevant empirical data suggests that adolescents, especially those age 14 and older, may have as well developed decisional skills as adults for making informed health care decisions.[20-22] Ethical and legal factors, (ie, confidentiality and/or privacy), suggest that the physician involve parents after appropriate discussion with the adolescent elicits his or her permission to do so. In some cases in which the patient has no legal entitlement to authorize treatment, the physician may have a legal obligation in some jurisdictions to obtain **parental permission** or to notify parents in addition to obtaining the patient's consent. An adolescent's refusal of consent in cases such as these may well be legally (and ethically) binding. If "conflict resolution" fails, formal legal adjudication may be needed.

CONCLUSION

A re-analysis of informed consent leads to the identification of important limitations and problems in its application to pediatric practice. Two additional concepts are needed: **parental permission** and **patient assent**. The American Academy of Pediatrics believes that in most cases, physicians have an ethical (and legal) obligation to obtain **parental permission** to undertaken recommended medical interventions. In many circumstances, physicians should also solicit a **patient assent** when developmentally appropriate. In cases involving emancipated or mature minors with adequate decision-making capacity, or when otherwise permitted by law, physicians should seek **informed consent** directly from patients.

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This statement has been approved by the Council on Child and Adolescent Health.

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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American
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Policy Statement

April, 1989

AAP News

Confidentiality in Adolescent Health Care (RE9151)

AMERICAN ACADEMY OF PEDIATRICS

This statement was approved as policy by the following organizations: the American Academy of Pediatrics; the American Academy of Family Physicians; the American College of Obstetricians and Gynecologists; NAACOG-The Organization for Obstetric, Gynecologic, and Neonatal Nurses; and the National Medical Associations.

Adolescents tend to underutilize existing health care resources. The issue of confidentiality has been identified, by both providers and young people themselves, as a significant access barrier to health care.

Adolescents in the United States, while generally considered healthy, have a range of problems, including some of such severity as to jeopardize their development and health, their future opportunities and even their lives. To illustrate, there is an urgent need to reduce the incidence of adolescent suicide, substance abuse, and sexually transmitted diseases and unintended pregnancy.

As the primary providers of health care to adolescents, we urge the following principles for the guidance of our professional members and for broad consideration in the development of public policy:

1. Health professionals have an ethical obligation to provide the best possible care and counseling to respond to the needs of their adolescent patients.
2. This obligation includes every reasonable effort to encourage the adolescent to involve parents, whose support can, in many circumstances, increase the potential for dealing with the adolescent's problems on a continuing basis.
3. Parents are frequently in a patient relationship with the same providers as their children or have been exercising decision-making responsibility for their children with these providers. At the time providers establish an independent relationship with adolescents as patients, the providers should make this new relationship clear to parents and adolescents with regard to the following elements:
 - * The adolescent will have an opportunity for examination and counseling apart from parents, and the same confidentiality will be preserved between the adolescent patient and the provider as between the parent/adult and the provider.
 - * The adolescent must understand under what circumstances (eg, life-threatening emergency), the provider will abrogate this confidentiality.
 - * Parents should be encouraged to work out means to facilitate communication regarding appointments, payment, or other matters consistent with the understanding reached about confidentiality and parental support in this transitional period when the adolescent is moving toward self-responsibility for health care.
4. Providers, parents, and adolescents need to be aware of the nature and effect of laws and regulations in their jurisdictions that introduce further constraints on these relationships. Some of these laws and regulations are unduly restrictive and in need of revision as a matter of public policy. Ultimately, the health risks to the adolescent are so impelling that legal barriers and deference to parental involvement should not stand in the way of needed health care.

Reaffirmed 1/93.

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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Medical Record-Keeping

Practices differ in their medical record filing systems from handwritten notes to electronic records; however, there are some standards that medical records should meet:

- Typed notes are suggested, but hand-written notes are acceptable, if legible.
- Documentation in the chart should contain:
 - Problem list of significant medical conditions and illnesses.
 - Allergies
 - Documentation in office visits of history and identity of the historian, physical findings, diagnosis consistent with findings and treatment plans. The use of "SOAP" format is highly recommended.
 - All lab, X-ray results initialed by physician to signify review.
 - Each and every page in chart contains the patient's name and/or ID number.
 - All entries in record are dated and signed.
 - Up-to-date immunization record.
 - Consultant requests are documented with follow-up recommendations/comments
 - For children twelve (12) years of age and older, there is documentation concerning discussion of cigarette, alcohol and substance abuse.
- EPSDT screening exams must have documentation of seven (7) components. This documentation should be in a format that is easily accessible and includes documentation that abnormal findings were recognized and appropriately treated or referred. Outcomes of treatment or referrals must be documented.

The seven (7) EPSDT screening components follow:

1. A comprehensive health and developmental history to include both physical and mental health;
2. Comprehensive unclothed physical exam;
3. Appropriate vision assessment;
4. Appropriate hearing assessment;
5. Laboratory tests appropriate for age and risk;
6. Immunizations; and
7. Health Education (anticipatory guidance).

Early and Periodic Screening, Diagnosis and Treatment Guidelines

Every child under the age of 21 years is eligible for Early and Periodic Screening, Diagnosis and Testing (EPSDT) and should receive checkups, even if there is no apparent health problem. The BPN PCP is expected to provide a "medical home" for the BPN Members assigned to him/her.

BPN Members may pose special management issues because they may have incomplete or poorly documented health records and they may present to the BPN PCP without a reliable medical history. The following guidelines are intended to assist the BPN PCP in determining need for EPSDT screenings for newly assigned BPN Members. **Note: The Department of Children's Services (DCS) will schedule appointments for EPSDT screenings within three (3) days of being enrolled in the Best Practice Network or as soon as a PCP is assigned. The initial EPSDT screening must be performed within twenty-one (21) days of the child's entering state custody.**

- If the BPN Member had a screening on schedule and prior to entering state custody, and DCS can provide the BPN PCP access to those records, and there is no indication that an inter-periodic screen is indicated (untreated or worsening medical or behavior problem), then there is no need to repeat the screen.
- A repeat screen is indicated if the results of the last screen are:
 - not available; **or**
 - the last screen identified problems that were not followed-up; **or**
 - identified problems have worsened or persisted; **or**
 - there is reason to suspect abuse; **or**
 - no problems were identified, but medical or behavioral problems contributed to the child entering into the Best Practice Network.
- If the BPN Member presents to the BPN PCP with an inadequate history and unreliable historian, the BPN PCP should complete as much screen as possible, notify the DCS case worker of what additional information is needed, and reschedule the Member for a follow-up interperiodic exam.

EPSDT Screening

EPSDT examination has the following seven (7) required components:

1. A comprehensive health and developmental history to include both physical and mental health;
2. Comprehensive unclothed physical exam;
3. Appropriate vision assessment;
4. Appropriate hearing assessment;
5. Laboratory tests appropriate for age and risk;
6. Immunizations; and
7. Health Education (anticipatory guidance).

EPSDT Periodicity Schedule

IN-OFFICE ENCOUNTERS	INFANCY						
	0	1	2	3	4	5	6
AGE	Newborn	2 Wks	2 Mo	4 Mo	6 Mo	9 Mo	12 Mo
HISTORY <i>Initial/Interval</i>	●	●	●	●	●	●	●
MEASUREMENTS <i>Height and Weight</i> <i>Head Circumference</i> <i>Blood Pressure</i>	● ●	● ●	● ●	● ●	● ●	● ●	● ●
SENSORY SCREENING <i>Vision</i> <i>Hearing</i>	S S/O	S S	S S	S S	S S	S S	S S
DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT			●	●	●	●	●
PHYSICAL EXAMINATION	●	●	●	●	●	●	●
PROCEDURES/TESTS <i>Hereditary/Metabolic Screening</i> <i>Immunization</i> <i>Tuberculin Test</i> <i>Hematocrit or Hemoglobin</i> <i>Urinalysis</i> <i>Lead Screening</i> <i>Serum Cholesterol</i> <i>STD</i> <i>Pelvic Exam</i>	● ● 	→ → 	● 	● 	● 	● ● * →	← * →
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●
DENTAL REFERRAL							←

Key

- To be performed
- S Service is subjective, by history
- O Service is objective, by a standard testing method
- * To be performed for patients at risk
- ←●→ The range during which a service may be provided, with the dot indicating the preferred age.

EPSDT Periodicity Schedule

	EARLY CHILDHOOD				
IN-OFFICE ENCOUNTERS	7	8	9	10	11
AGE	15 Mo	18 Mo	24 Mo	3 Yrs	4 Yrs
HISTORY <i>Initial/Interval</i>	●	●	●	●	●
MEASUREMENTS <i>Height and Weight</i> <i>Head Circumference</i> <i>Blood Pressure</i>	● ●	● ●	● ●	● ● ●	● ● ●
SENSORY SCREENING <i>Vision</i> <i>Hearing</i>	S S	S S	S S	O O	
DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT	●	●	●	●	●
PHYSICAL EXAMINATION	●	●	●	●	●
PROCEDURES/TESTS <i>Hereditary/Metabolic Screening</i> <i>Immunization</i> <i>Tuberculin Test</i> <i>Hematocrit or Hemoglobin</i> <i>Urinalysis</i> <i>Lead Screening</i> <i>Serum Cholesterol</i> <i>STD</i> <i>Pelvic Exam</i>	● * * * * * * * * *	→ * * * S * * * *	* * * * * * * * *	* * * * * * * * *	* * * * * * * * *
ANTICIPATORY GUIDANCE	●	●	●	●	●
DENTAL REFERRAL				●	●

Key

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- S Service is subjective, by history
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- * To be performed for patients at risk
- ←●→ The range during which a service may be provided, with the dot indicating the preferred age.

EPSDT Periodicity Schedule

	MIDDLE CHILDHOOD			
IN-OFFICE ENCOUNTERS	12	13	14	15
AGE	5 Yrs	6 Yrs	8 Yrs	10 Yrs
HISTORY <i>Initial/Interval</i>	●	●	●	●
MEASUREMENTS <i>Height and Weight</i> <i>Head Circumference</i> <i>Blood Pressure</i>	● ● ●	● ● ●	● ● ●	● ● ●
SENSORY SCREENING <i>Vision</i> <i>Hearing</i>	→ →	S S	S S	O O
DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT	●	●	●	●
PHYSICAL EXAMINATION	●	●	●	●
PROCEDURES/TESTS <i>Hereditary/Metabolic Screening</i> <i>Immunization</i> <i>Tuberculin Test</i> <i>Hematocrit or Hemoglobin</i> <i>Urinalysis</i> <i>Lead Screening</i> <i>Serum Cholesterol</i> <i>STD</i> <i>Pelvic Exam</i>	● → * ● → * * * *	→ * * * * * * * *	* * * * * * * * *	* * * * * * * * *
ANTICIPATORY GUIDANCE	●	●	●	●
DENTAL REFERRAL	●	●	●	●

Key

- To be performed
- S Service is subjective, by history
- O Service is objective, by a standard testing method
- * To be performed for patients at risk
- The range during which a service may be provided, with the dot indicating the preferred age.

EPSDT Periodicity Schedule

	ADOLESCENCE									
	EARLY			MIDDLE			LATE			
IN-OFFICE ENCOUNTERS	16	17	18	19	20	21	22	23	24	25
AGE	11	12	13	14	15	16	17	18	19	20
HISTORY <i>Initial/Interval</i>	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS <i>Height and Weight</i> <i>Head Circumference</i> <i>Blood Pressure</i>	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING <i>Vision</i> <i>Hearing</i>	→			O	→				S	S
DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION	●	●	●	●	●	●	●	●	●	●
PROCEDURES/TESTS <i>Hereditary/Metabolic Screening</i> <i>Immunization</i> <i>Tuberculin Test</i> <i>Hematocrit or Hemoglobin</i> <i>Urinalysis</i> <i>Lead Screening</i> <i>Serum Cholesterol</i> <i>STD</i> <i>Pelvic Exam</i>	●	→								
	*	*	*	*	*	*	*	*	*	*
	→				●	→				
	→				●	→				
	*	*	*	*	*	*	*	*	*	*
	*	*	*	*	*	*	*	*	*	*
	*	*	*	*	*	*	*	●	●	●
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●
DENTAL REFERRAL	●	●	●	●	●	●	●	●	●	●

Key

- To be performed
- S Service is subjective, by history
- O Service is objective, by a standard testing method
- * To be performed for patients at risk
- The range during which a service may be provided, with the dot indicating the preferred age.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Screening Guidelines

Periodicity Schedule

The periodic intervals for screening as shown in the Periodicity Schedule (See Section II.), are based on American Academy of Pediatric recommendations (1999), and TennCareSM Bureau guidelines. The Periodicity Schedule should be used in determining the correct ages to perform preventive visits ("well checkups") as well as to determine the age appropriate screening. More frequent screening should be done as medically indicated. All of the age appropriate screening components must be completed in each preventive checkup visit.

Screening Components

History – Initial and Interval History: This comprehensive history may be obtained from interview of the parent or guardian or through a form or checklist completed by the parent or guardian. The history must contain, but is not limited to:

- ✓ Present health status and past health history of recipient
- ✓ Developmental information
- ✓ Allergies and immunization history
- ✓ Family history
- ✓ Dietary history
- ✓ Age appropriate social history
- ✓ Current medication(s)

Documentation: Once the health history is recorded in the medical record, only an update is required for subsequent visits.

Complete Physical Examination: The physical examination must be performed with the child **unclothed** but suitably draped. A comprehensive physical examination must be completed, including an examination of the heart with a stethoscope and check of the general appearance of the child to determine overall health status. This process can pick up obvious physical defects, including nutritional abnormalities, orthopedic disorders, hernia, skin disease, and genital abnormalities.

The following measurements are very important during the developmental years and should be recorded and compared to those considered normal for the same age.

Measurements:

The **Head circumference** should be measured with a tape measure at each visit during the first two years of life.

The **Height** should be measured with each visit. The height for infants up to two (2) years should be measured as recumbent length using a properly constructed measuring device. Height measurements for children two (2) years and over should be accomplished using a vertical measuring board or fixed wall device.

The **Weight** should be measured at all ages with the child nude or wearing an examination gown.

Blood Pressure (B/P) Monitoring: should begin at the age of three (3) years unless there is a clinical indication to begin prior to that time. The B/P should be measured at each screening visit using an appropriate sized cuff.

Documentation: Measurements in numerical values are to be recorded in the medical record. The head circumference, height, and weight should also be plotted on an age appropriate Growth chart. Growth charts can be obtained from the State of Tennessee Department of Health Nutrition Division, Nashville, TN. Limited copies may be obtained at local county health departments.

Sensory Screening

Vision: All children should have an eye exam using ophthalmoscope. In addition, all children should have additional vision screening that is age appropriate. This includes screening for ocular alignment, visual acuity and physical abnormalities of the eye.

See age specific vision screening recommendations in **III.b.**

Documentation: The examination(s) performed and results should be recorded in the medical record. Referrals should be documented.

Hearing: Significant hearing loss can be present at birth and, if undetected, will impede speech, language, and cognitive development. Newborn hearing screenings are most likely to occur in hospital with results reported to the primary care provider. Acceptable methods of screening include auditory brainstem response (ABR) and otoacoustic emissions (OAE).

Screening the hearing in infants and young children up to the age of three (3) may be accomplished using Denver noise makers, voice, etc., and subjectively by parental observation. Objective hearing measurements should be done as early as age three years and as indicated on the periodicity schedule. Bilateral audiometric screening should be done with pure tones of 20dB HL at 500 , 1000, 2000 and 4000 Hz. See age specific hearing screening recommendations in **III.b.**

Documentation: Results of the screening must be recorded in the medical record indicating passed or failed. Positive screening results should lead to referral for diagnostic assessment of hearing. However a prompt re-screening may be done prior to referral if the clinician believes the initial screening result is likely to be a false positive. Re-screening should be done within 2-4 weeks rather than waiting until the next scheduled well child visit. All screening and results must be documented in the medical record.

Developmental/Behavioral Screening

Watching a young child grow is a wonderful and unique experience. Learning to sit up, walk, and talk are the major developmental "milestones" a child will achieve. However, a child's growth is a complex and ongoing process. Young bodies are constantly going through a number of mental as well as physical changes.

Although no two children develop at the same rate, they should be able to do certain things at certain ages. Early identification of children with developmental disabilities leads to effective therapy of those conditions for which definitive treatment is available. The child's Primary Care Practitioner (PCP) must work with the parents to monitor the child's development. A range of activities is evaluated to determine whether an individual's developmental processes fall within a

normal range of achievements according to age group and cultural background. Age specific developmental "milestones" must be assessed at each preventive visit.

Developmental/behavioral screening is an ongoing process that is most effectively performed using **standardized screening tests**. See **Section III.c.** for age-specific developmental/behavioral screening questionnaires and checklists that should be used to elicit information. The TennCareSM Screening Guidelines Committee recommends the use of standardized validated developmental behavioral screening tools. Non-standardized questionnaires or checklists are acceptable.

If findings appear abnormal, these children should be referred to an appropriate diagnosis/treatment provider for further evaluation and/or treatment.

Documentation: Results of developmental/behavioral screening must be documented in the medical record. A copy of questionnaires or checklists used must be retained in the medical record. Referrals, if indicated, must also be documented in the medical record.

Lab Procedures/Immunizations

Newborn Metabolic Screening

The Tennessee State law requires that every newborn be tested for metabolic/genetic defects that would result in mental retardation or physical dysfunction if not treated in a timely manner. The following tests are required:

- ✓ Phenylketonuria
- ✓ Hypothyroidism
- ✓ Hemoglobinopathies
- ✓ Galactosemia

These tests are generally done while the infant is still in the hospital nursery. However, there may be instances when this is not done (ex. Infants born at home). The PCP must ensure that these tests have been done in a timely manner. If discrepancies are found, the provider should notify the local Health Department.

Documentation: On screening visits between birth and two months, the provider should document that testing has been completed, as well as test results. This information or instructions on how to obtain it, may be obtained from the local Health Department.

Immunizations

By ensuring that children get immunized on time, we can provide the best available defense against many dangerous childhood diseases. Immunizations protect children against: *hepatitis B, polio, measles, mumps, rubella (German measles), pertussis (whooping cough), diphtheria, tetanus (lockjaw), Haemophilus, influenza type b, and chickenpox.*

Immunizations, if needed, should be given at the time of the preventive/checkup visit or at any other contact with the child. See the American Academy of Pediatrics' U.S. Recommended Childhood Immunization Schedule regarding recommended ages for routine administration of currently licensed childhood vaccines (See **Resources V.g.**).

Documentation: All Immunizations must be documented in the medical record indicating type, lot number, date and signature, as well as any adverse reactions. If immunizations have been given at another facility, a copy of that record should be retrieved for the current record. Immunizations not given by the PCP must be documented in the medical record, not only with the date the immunization was given, but also with the date the information was documented in the current record.

Lead Screening

Children enrolled in Medicaid have a greater chance of having elevated blood lead levels than other children. Blood lead levels (BLLs) as low as 10 mcg/dL are associated with harmful effects on children's learning and behavior. Very high BLL (≥ 70 mcg/dL) can cause devastating health consequences, including seizures, coma, and death.

Health Care Financing Administration (HCFA) policy calls for children enrolled in Medicaid (TennCareSM) to have their BLL measured at 12 and 24 months of age, while children are 36-72 months should be tested if they were missed earlier. (*State Medicaid Manual*, September 1998, Paragraph 513.2).

In children with screening BLL > 10 mcg/dL, the first step is to perform a confirmatory venous BLL. This should be performed immediately if screening BLL > 70 mcg/dL (urgent condition requiring hospitalization); within 48 hours if screening result is 45-69 mcg/dL; within 1 week if screening result is 20-44 mcg/dL; within 1 month if screening result is 10-19 mcg/dL.

Documentation: The medical record must contain laboratory report of test results. Diagnosis, treatment, education and follow-up should be documented in the medical record.

Tuberculin Test

The TB Risk Assessment Questionnaire (**See Resources V.d.**) should be completed beginning at age 12 months and at each screening thereafter, in order to determine risk. For high risk groups, the Committee on Infectious Disease recommends TB skin testing immediately and every 1-3 years.

TB skin test results should be read and documented by a health professional. The Health Department must be notified of any high risk child or any positive skin test reading.

Documentation: The administration of the tuberculin skin test and the results must be recorded in the medical record with appropriate dates and signatures. Treatment and/or referral must also be documented in the medical record.

Hematocrit or Hemoglobin (Hct./Hgb.)

Hgb. and Hct. screening should be done at or by ages 9 months and 15 years. Annual Hct. or Hgb screening should be done on females presenting with the following:

- ✓ Moderate to heavy menses
- ✓ Chronic weight loss
- ✓ Nutritional deficit
- ✓ Athletic activity

Documentation:

Test results as well as any further evaluation, treatment, counseling or referral must be documented in the medical record.

Cholesterol Screening

Initial screening should be done as early as age two years. The following AAP Guidelines (www.aap.org, policy RE 9805) provide specific recommendations for selective screening of children and adolescents in the context of their continuing health care.

1. Screen children and adolescents whose parents or grandparents, at ≤ 55 years of age, underwent diagnostic coronary arteriography and were found to have coronary atherosclerosis. This includes those who have undergone balloon angioplasty or coronary artery bypass surgery.
2. Screen children and adolescents whose parents or grandparents, at ≤ 55 years of age, had a documented myocardial infarction, angina pectoris, peripheral vascular disease, cerebrovascular disease, or sudden cardiac death.
3. Screen the offspring of a parent with an elevated blood cholesterol level (240 mg/dl or higher).
4. For children and adolescents whose parental history is unobtainable, particularly for those with other risk factors, physicians may choose to measure cholesterol levels to identify those in need of nutritional and medical advice.

Optional cholesterol testing by practicing physicians may be appropriate for children who are judged to be at higher risk for coronary heart disease independent of family history. For example, adolescents who smoke, consume excessive amounts of saturated fats and cholesterol, or are overweight may also be tested at the discretion of their PCP. For parents who do not know their cholesterol levels, PCPs should strongly encourage them to have their levels measured.

Urine Testing

Most infection-related renal damage occurs during infancy and early childhood. Timely identification of infection, appropriate treatment, detection of patients at risk for renal scarring, and prevention of recurrent infection can greatly reduce the risk of an adverse outcome.

A minimum, of one (1) dip stick urine must be performed at five (5) years of age and during each time period as shown thereafter on the periodicity Schedule. Performance of additional testing is left to the discretion of the individual practitioner.

Documentation: Test results, as well as appropriate treatment and referral, if indicated, must be recorded in the medical record.

Sexually Transmitted Diseases (STDs)

Adolescence is a time of experimentation and risk taking. Developmentally, adolescents are at a crossroads of health. Emerging cognitive abilities and social experiences lead adolescents to question adult values and experiment with health risk behaviors. Some behaviors threaten current health, while others may have long-term health consequences.

All adolescents should be asked about involvement in sexual behaviors that may result in unintended pregnancy and STDs, including HIV infection. They should receive health guidance annually regarding responsible sexual behaviors, including abstinence. Latex condoms to prevent STDs, including HIV infection, and appropriate methods of birth control should be made available, as should instructions on how to properly use them. All sexually active adolescents should be screened annually for STDs or more often if deemed medically necessary.

Documentation: STD screening and results must be documented in the medical record as well as education and treatment, if indicated. The local Health Department must be notified of all positive STDs.

Pelvic Examination

All sexually active adolescents or any female 18 or older should be screened annually for cervical cancer by use of a Pap test. Adolescents with a positive Pap test should be referred for further diagnostic assessment and management.

Documentation: Findings on pelvic examination as well as Pap results must be documented in the medical record. Referral(s), if indicated, must be documented as well.

Anticipatory Guidance/Health Education

Anticipatory guidance and health education are an integral part of the screening and must be provided by the professional. Age appropriate topics/information must be presented during each screen. Providers should use oral and written information.

Documentation: Specific topics discussed or written information distributed must be documented in the medical record. If the age appropriate encounter form is used, simply checking the items that apply is all that is necessary. However, any and all documentation should be dated and signed appropriately.

Dental Screening

Dental care includes emergency and preventive services and therapeutic services for dental disease which, if left untreated, may become acute dental problems or may cause irreversible damage to the teeth or supportive structures. Maintenance of good dental health, requires the beginning of dental care at an early age.

Although an oral screening is part of the physical examination, it does not substitute for screening examination performed by a dentist. A direct dental referral is required for every child in accordance with the periodicity schedule. Children must be referred to a dentist for routine dental care beginning at age three (3) and yearly thereafter. However, if deemed medically necessary, a dental referral may be made at any age.

Documentation: Dental inspection as well as referral and education must be documented in the medical record.

References:

Committee on Nutrition, Cholesterol in Childhood. Pediatrics, Vol. 101, (1), Jan. '98. 141-147.
www.aap.org, Policy RE 9805

Preventing Lead Poisoning in Young Children: A Statement by the Center for Disease Control, Atlanta, 1991, US Dept of Health & Human Services

Dershewitz, Robert A., "Ambulatory Pediatric Care", 2nd. Ed., Lippincott. 1993.

Bright Futures <http://www.brightfutures.org>

GAP Adolescent Health on line – American Medical Association
Department of Adolescent Health, American Medical Association, 515 North State Street,
Chicago, IL 60610 <http://www.ama-assn.org/ado/hlth/adolhlth.htm>

HCFA Child Care & Medicaid: Partners for Healthy Children
<http://www.hcfa.gov/medicaid/ch%2Dguide.htm>

Recommendations of the TennCareSM EPSDT Screening Guidelines

Committee Hearing and Vision Screenings - January 1999

	RECOMMENDATIONS FOR HEARING SCREENING		RECOMMENDATIONS FOR VISION SCREENING	
	Subjective	Objective	Subjective	Objective
Newborn	<ul style="list-style-type: none"> Parental perception of hearing Family history Wakes to loud noises Head turning with voice/noise 	<ul style="list-style-type: none"> ABR or OAE, if performed in hospital Observational screening with noisemaker (optional) 		<ul style="list-style-type: none"> Eye exam: red reflex, corneal inspection
2-4 days	<ul style="list-style-type: none"> Parental perception of hearing Family history Responses to voice and noise – parent report 	<ul style="list-style-type: none"> ABR or OAE, if performed in hospital Observational screening with noisemaker (optional) 		<ul style="list-style-type: none"> Eye exam: red reflex, corneal inspection
By 1 month	<ul style="list-style-type: none"> Parental perception of hearing Family history (unless previously recorded) Response to voice and noise – parent report 	<ul style="list-style-type: none"> Ear exam Observational screening with noisemaker (optional) 	<ul style="list-style-type: none"> Parental perception of vision 	<ul style="list-style-type: none"> Eye exam: red reflex, corneal inspection Fixes on face, follows with eyes
2 months	<ul style="list-style-type: none"> Parental perception of hearing Family history (unless previously recorded) Response to voice and noise – parent report 	<ul style="list-style-type: none"> Ear exam Observational screening with noisemaker (optional) 	<ul style="list-style-type: none"> Parental perception of vision 	<ul style="list-style-type: none"> Eye exam: red reflex, corneal inspection Fixes on face, follows with eyes
3 months	<ul style="list-style-type: none"> Parental perception of hearing Family history (unless previously recorded) Response to voice and noise – parent report 	<ul style="list-style-type: none"> Ear exam Observational screening with noisemaker (optional) 	<ul style="list-style-type: none"> Parental perception of vision 	<ul style="list-style-type: none"> Eye exam Fixes and follows each eye
4 months	<ul style="list-style-type: none"> Parental perception of hearing Recognizes parent's voice –parent report Family history (unless previously recorded) 	<ul style="list-style-type: none"> Ear exam Observational screening with noisemaker (optional) 	<ul style="list-style-type: none"> Parental perception of vision 	<ul style="list-style-type: none"> Eye exam Fixes and follows each eye
6 months	<ul style="list-style-type: none"> Parental perception of hearing Turns to sounds –parent report Family history (unless previously recorded) 	<ul style="list-style-type: none"> Ear exam Observational screening with noisemaker (optional) 	<ul style="list-style-type: none"> Parental perception of vision 	<ul style="list-style-type: none"> Eye exam Fixes and follows each eye
9 months	<ul style="list-style-type: none"> Parental perception of hearing Response to voice and noise – parent report Family history (unless previously recorded) 	<ul style="list-style-type: none"> Ear exam Observational screening with noisemaker (optional) 	<ul style="list-style-type: none"> Parental perception of vision 	<ul style="list-style-type: none"> Eye exam Fixes and follows each eye
12 months	<ul style="list-style-type: none"> Parental perception of hearing Response to voice and noise – parent report Family history (unless previously recorded) 	<ul style="list-style-type: none"> Ear exam Observational screening with noisemaker (optional) 	<ul style="list-style-type: none"> Parental perception of vision 	<ul style="list-style-type: none"> Eye exam Fixes and follows each eye

	RECOMMENDATIONS FOR HEARING SCREENING		RECOMMENDATIONS FOR VISION SCREENING	
	Subjective	Objective	Subjective	Objective
15 months	<ul style="list-style-type: none"> • Parental perception of hearing • Response to voice and noise – parent report • Family history (unless previously recorded) 	<ul style="list-style-type: none"> • Ear exam • Observational screening with noisemaker (optional) 	<ul style="list-style-type: none"> • Parental perception of vision • Can see small objects 	<ul style="list-style-type: none"> • Eye exam • Can see small objects
18 months	<ul style="list-style-type: none"> • Parental perception of hearing • Response to voice and noise – parent report • Family history (unless previously recorded) 	<ul style="list-style-type: none"> • Ear exam • Observational screening with noisemaker (optional) 	<ul style="list-style-type: none"> • Parental perception of vision • Can see small objects 	<ul style="list-style-type: none"> • Eye exam • Can see small objects
24 months	<ul style="list-style-type: none"> • Parental perception of hearing • Response to voice and noise – parent report • Family history (unless previously recorded) 	<ul style="list-style-type: none"> • Ear exam • Observational screening with noisemaker (optional) 	<ul style="list-style-type: none"> • Parental perception of vision • Can see small objects 	<ul style="list-style-type: none"> • Eye exam • Can see small objects
3 years	<ul style="list-style-type: none"> • Parental perception of hearing 	<ul style="list-style-type: none"> • Ear exam • Hearing screen (optional) • Observational screening with noisemaker (optional) 	<ul style="list-style-type: none"> • Parental perception of vision • Can see small objects 	<ul style="list-style-type: none"> • Eye exam • Ocular alignment, visual acuity (optional) • Can see small objects
4 years	<ul style="list-style-type: none"> • Parental perception of hearing 	<ul style="list-style-type: none"> • Ear exam • Hearing screen (if not done at 3 years) 	<ul style="list-style-type: none"> • Parental perception of vision 	<ul style="list-style-type: none"> • Eye exam • Ocular alignment, visual acuity (if not done at 3 years)
5 years	<ul style="list-style-type: none"> • Parental perception of hearing 	<ul style="list-style-type: none"> • Ear exam • Hearing screen (if not done at 3 or 4 years) 	<ul style="list-style-type: none"> • Parental perception of vision 	<ul style="list-style-type: none"> • Eye exam • Ocular alignment, visual acuity (if not done at 3 or 4 years)
6 years	<ul style="list-style-type: none"> • Parental perception of hearing 	<ul style="list-style-type: none"> • Ear exam • Hearing screen (if not done at 3, 4, or 5 years) 	<ul style="list-style-type: none"> • Parental perception of vision 	<ul style="list-style-type: none"> • Eye exam • Ocular alignment, visual acuity (if not done at 3, 4, or 5 years)
7 years	<ul style="list-style-type: none"> • Parental and patient perception of hearing 	<ul style="list-style-type: none"> • Ear exam • Hearing screen 	<ul style="list-style-type: none"> • Parental and patient perception of vision 	<ul style="list-style-type: none"> • Eye exam
8 years	<ul style="list-style-type: none"> • Parental and patient perception of hearing 	<ul style="list-style-type: none"> • Ear exam • Hearing screen (if not done at 7 years) 	<ul style="list-style-type: none"> • Parental and patient perception of vision 	<ul style="list-style-type: none"> • Eye exam
9 years	<ul style="list-style-type: none"> • Parental and patient perception of hearing 	<ul style="list-style-type: none"> • Ear exam • Hearing screen (if not done at 7 or 8 years) 	<ul style="list-style-type: none"> • Parental and patient perception of vision 	<ul style="list-style-type: none"> • Eye exam
10 years	<ul style="list-style-type: none"> • Parental and patient perception of hearing 	<ul style="list-style-type: none"> • Ear exam • Hearing screen (if not done at 7, 8, or 9 years) 	<ul style="list-style-type: none"> • Parental and patient perception of vision 	<ul style="list-style-type: none"> • Eye exam • Visual acuity
11 years	<ul style="list-style-type: none"> • Parental and patient perception of hearing 	<ul style="list-style-type: none"> • Ear exam • Hearing screen (if not done at 7, 8, 9, or 10 years) 	<ul style="list-style-type: none"> • Parental and patient perception of vision 	<ul style="list-style-type: none"> • Eye exam • Visual acuity (if not done at 10 years)
12 years	<ul style="list-style-type: none"> • Parental and patient perception of hearing 	<ul style="list-style-type: none"> • Ear exam • Hearing screen (if not done at 7, 8, 9, 10 or 11 years) 	<ul style="list-style-type: none"> • Parental and patient perception of vision 	<ul style="list-style-type: none"> • Eye exam • Visual acuity (if not done at 10 or 11 years)
13 years	<ul style="list-style-type: none"> • Parental and patient perception of hearing 	<ul style="list-style-type: none"> • Ear exam • Hearing screen (if not done at 7, 8, 9, 10, 11 or 12 years) 	<ul style="list-style-type: none"> • Parental and patient perception of vision 	<ul style="list-style-type: none"> • Eye exam • Visual acuity (if not done at 10, 11 or 12 years)

	RECOMMENDATIONS FOR HEARING SCREENING		RECOMMENDATIONS FOR VISION SCREENING	
	Subjective	Objective	Subjective	Objective
14 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen	• Parental and patient perception of vision	• Eye exam • Visual acuity
15 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen (if not done at 14 years)	• Parental and patient perception of vision	• Eye exam • Visual acuity (if not done at 14 years)
16 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen (if not done at 14 or 15 years)	• Parental and patient perception of vision	• Eye exam • Visual acuity (if not done at 14 or 15 years)
17 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen (if not done at 14, 15 or 16 years)	• Parental and patient perception of vision	• Eye exam • Visual acuity (if not done at 14, 15, or 16 years)
18 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen (if not done at 14, 15, 16 or 17 years)	• Parental and patient perception of vision	• Eye exam • Visual acuity (if not done at 14, 15, 16 or 17 years)
19 years	• Parental and patient perception of hearing	• Ear exam	• Parental and patient perception of vision	• Eye exam
20 years	• Parental and patient perception of hearing	• Ear exam	• Parental and patient perception of vision	• Eye exam
21 years	• Parental and patient perception of hearing	• Ear exam	• Parental and patient perception of vision	• Eye exam

Hearing Screening

- Newborn hearing screenings are most likely to occur in hospital with results reported to the primary care provider. Acceptable methods of screening include auditory brainstem response (ABR) and otoacoustic emissions (OAE) with thresholds of 30 dB HL.
- Newborn hearing screening is recommended for all newborn infants. As of January, 1999, not all hospitals in the State have the capability of conducting newborn hearing screening. Newborn hearing screenings should be provided for all newborns by the year 2003.
- Recommended testing intervals: The committee recommends an objective hearing screening test once in each of the following age ranges: 3-6, 10-13, 14-18. Screening should be conducted at the first visit during the above listed intervals at which the patient is cooperative.
- Acceptable methods of objective hearing screening include: conventional audiometry, hand-held audiometry, conditioned play audiometry (with a screening level of 20 dB HL at 500, 1000, 2000, and 4000 Hz).
- Positive screening results should lead to referral for diagnostic assessment of hearing. A prompt re-screening may be substituted for immediate referral for diagnostic assessment if the clinician believes the initial screening result is likely to be a false positive. Re-screening should be done within 2-4 weeks rather than waiting until the next scheduled well child visit.

Vision Screening

- Recommended testing intervals:
 - The committee recommends testing ocular alignment and visual acuity once in the 3-6 year old age range. These procedures should be conducted at the first visit during which the patient is cooperative.
 - The committee recommends testing visual acuity once in each of the following age ranges: 10-13, 14-18

Developmental/Emotional/Behavioral Screening Tools Recommended for Use in EPSDT Screenings

The following chart is a list of measures approved for use in EPSDT screenings. The "Description" column provides information on alternative ways (if available) to administer measures (e.g., waiting rooms). The "Accuracy" column shows the percentage of patients with and without problems identified correctly. The "Time Frame/Costs" column shows the costs of materials per visit along with the costs of professional time needed to administer each measure. For parent report tools, administration time reflects not only scoring of test results, but also the relationship between each test's reading level and the percentage of TennCareSM patients with less than a high school education (who may or may not be able to complete measures in waiting rooms due to literacy problems and will thus need interview administrations).

TOOLS THAT ARE RECOMMENDED FOR USE IN EPSDT SCREENINGS

Measure	Age range	Description	Scoring	Accuracy	Time Frame
Child Development Inventories (formerly Minnesota Child Development Inventories) (1992) Behavior Science Systems Box 580274, Minneapolis, MN 55458 (phone: 612-929-6220)	Birth to 72 months	60 yes/no descriptions with separate forms for 0-18 months, 18-36 months, and 3-6 years. Can be mailed to families, completed in waiting rooms, admini- stered by interview or by direct elicitation	A single cutoff tied to 1.5 standard deviations below the mean	Sensitivity ¹ was 75% or greater across studies and specificity ² was 70%	About 10 minutes (if interview needed)
Parents' Evaluation of Developmental Status (PEDS) (1997) Ellsworth & Vandermeer Press, Ltd. 4405 Scenic Drive, Nashville, TN. Phone 615-386-0061, fax: 615-386-0346 http://edge.net/~evpress	Birth to 9 years	10 questions eliciting parents' concerns. Can be administered in waiting rooms or by interview. Available in Spanish. Written at the 5th grade level. Normed in teaching hospitals and private practice	Categorizes patients into those needing referrals, screening, counseling, reassurance, extra monitoring	Sensitivity ranged from 74% to 79% and specificity ranged from 70% to 80%	About 2 minutes (if interview needed)
Pediatric Symptom Checklist Jellinek MS, Murphy JM, Robinson J et al. Pediatric Symptom Checklist. Screening school age children for psycho- social dysfunction. <i>Journal of Pediatrics</i> , 1988, 112:201-209 (the test is included in the article and in the PEDS manual)	6 to 16 years	35 short statements of problem behaviors to which parents respond with "never," "sometimes," or "often." The PSC screens for academic and emotional/ behavioral difficulties	Single refer/ nonrefer score	Sensitivity ranged from 80% to 95%. Specifically in all but one study was 70% to 100%	About 7 minutes (if interview needed)

TOOLS THAT ARE RECOMMENDED FOR SECONDARY SCREENING INVOLVING DIRECT TESTING OF CHILDREN

Brigance Screens , Billerica, MA Curriculum Associates, Inc. (1985) 153 Rangeway Road, N. Billerica, MA 01862 (1-800-225-0248)	21 to 90 months	Seven separate forms, one for each 12 month age. Taps speech-language, motor, readiness and general knowledge at younger ages and also reading and math at older ages. Uses direct elicitation and observation	Cutoff and age equivalent scores	Sensitivity and specificity to giftedness and to developmental and academic problems was 70% to 82%	10 minutes (direct testing only)
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TOOLS THAT ARE NOT RECOMMENDED BUT ARE ACCEPTABLE FOR AUDIT UNTIL 2003*

Denver-II	Birth to 6 years	Combination of directly elicited and interview, tapping language, personal-social, gross and fine motor, but not preacademic or academic skills	Pass/fail/ Questionable/ untestable	Sensitivity 80% and specificity 40% or sensitivity 40% and specificity 80%, depending on how the questionable score is handled	15 minutes for younger children, 25 minutes for older children (combination of direct and interview items)
Informal checklists (such as those imbedded in age-specific encounter forms such as Bright Futures)	Birth to 21 years	Usually tap different areas but lack scoring criteria, provide no proof that items tap important skills or predict developmental outcome.	None	Unknown, but research shows that informal methods detect fewer than 30% of children with disabilities	Unknown, but most have about 10 items and so may take about 2 minutes

¹Sensitivity = percentage of children with disabilities identified as probably delayed by a screening test

²Specificity = percentage of children without disabilities identified as probably normal by a screening test

* Note For Developmental/Behavioral Screening of older adolescents, informal checklist recommended because there are no standardized validated screening tools currently available for this age group

Pediatric Symptom Checklist

DATE _____ CHILD'S NAME _____ DOB _____

FILLED OUT BY: _____

Please mark under the heading that best fits your child:

		Never	Sometimes	Often
1.	Complains of aches/pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Spends more time alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Tires easily, little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Fidgety, unable to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Has trouble with a teacher	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Less interested in school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Acts as if driven by a motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Daydreams too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Distracted easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Is afraid of new situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Feels sad, unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Is irritable, angry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Feels hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	Has trouble concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	Less interest in friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16.	Fights with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17.	Absent from school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18.	School grades dropping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19.	Is down on him or herself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20.	Visits doctor with doctor finding nothing wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21.	Has trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22.	Worries a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23.	Wants to be with you more than before	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24.	Feels he or she is bad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25.	Takes unnecessary risks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26.	Gets hurt frequently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27.	Seems to be having less fun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28.	Acts younger than children his or her age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29.	Does not listen to rules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30.	Does not show feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31.	Does not understand other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32.	Teases others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33.	Blames others for his or her troubles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34.	Takes things that do not belong to him or her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35.	Refuses to share	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Comments

[illegible]

Developmental Milestones Checklist

CHILD'S NAME _____ DOB _____

2-4 Weeks

- | | |
|--|--|
| <input type="checkbox"/> Responds to sounds by startling, blinking, crying, quieting, or breathing | <input type="checkbox"/> Flexed posture |
| <input type="checkbox"/> Looks at face and follows with eyes | <input type="checkbox"/> Can sleep for three or four hours at a time |
| <input type="checkbox"/> Responds to parent's face and voice | <input type="checkbox"/> Can stay awake for one hour or longer |
| <input type="checkbox"/> Moves arms, legs and head | <input type="checkbox"/> When crying, can be consoled most of the time, by being spoken to or held |
| <input type="checkbox"/> On stomach, lifts head momentarily | |

Date _____

Signature _____

2 Months

- | | |
|---|--|
| <input type="checkbox"/> Coos and vocalizes reciprocally | <input type="checkbox"/> Lifts head, neck, and upper chest with support of forearms while on stomach |
| <input type="checkbox"/> Pays attention to voices, other sounds, sights | <input type="checkbox"/> Has some head control in upright position |
| <input type="checkbox"/> Smiles responsively | |
| <input type="checkbox"/> Shows pleasure with parents | |

Date _____

Signature _____

4 Months

- | | |
|--|--|
| <input type="checkbox"/> Babbles and coos | <input type="checkbox"/> Opens hands, holds own hands, grasps rattle |
| <input type="checkbox"/> Smiles, laughs, and squeals | <input type="checkbox"/> Good head control |
| <input type="checkbox"/> On stomach, holds head erect and raises body on hands | <input type="checkbox"/> Reaches for and bats objects |
| <input type="checkbox"/> Rolls over from stomach to back | <input type="checkbox"/> Recognizes parent's voice and touch |

Date _____

Signature _____

6 Months

- | | |
|--|--|
| <input type="checkbox"/> Babbles reciprocally | <input type="checkbox"/> Transfers cubes from hand to hand |
| <input type="checkbox"/> Says "dada" or "baba" | <input type="checkbox"/> Rakes in small objects |
| <input type="checkbox"/> When pulled to sit, has no head lag | <input type="checkbox"/> Self-comforts |
| <input type="checkbox"/> Sits with support | <input type="checkbox"/> Smiles, laughs, squeals, imitates razzing noise |
| <input type="checkbox"/> Stands when placed | <input type="checkbox"/> Turns to sounds |
| <input type="checkbox"/> Grasps and mouths objects | <input type="checkbox"/> May have first tooth |
| <input type="checkbox"/> Shows differential recognition of parents | |

Date _____

Signature _____

9 Months

- | | |
|--|--|
| <input type="checkbox"/> Responds to own name | <input type="checkbox"/> Pokes with finger, shakes, bangs, throws, and drops objects |
| <input type="checkbox"/> Understands a few words | <input type="checkbox"/> Plays peek-a-boo or pat-a-cake |
| <input type="checkbox"/> Babbles | <input type="checkbox"/> Feeds self with fingers |
| <input type="checkbox"/> Crawls, creeps, or scoots | <input type="checkbox"/> May show anxiety with strangers |
| <input type="checkbox"/> Sits unsupported | |

Date _____

Signature _____

Reference: Bright Futures

Note: This resource is not a standardized, validated screening tool. However, it is acceptable until year 2003. (See Section III c for recommended standardized, validated screening tools, if desired.)

Developmental Milestones Checklist

CHILD'S NAME _____ DOB _____

12 Months

- | | |
|--|--|
| <input type="checkbox"/> Pulls to stand, cruises, and may take a few steps alone | <input type="checkbox"/> Drinks from cup |
| <input type="checkbox"/> Plays pat-a-cake, peek-a-boo, or so-big | <input type="checkbox"/> Looks for dropped or hidden objects |
| <input type="checkbox"/> Points | <input type="checkbox"/> Waves "bye-bye" |
| <input type="checkbox"/> Bangs blocks together | <input type="checkbox"/> Feeds self |
| <input type="checkbox"/> Says 2-4 words, imitates vocalizations | |

Date _____

Signature _____

15 Months

- | | |
|--|--|
| <input type="checkbox"/> Says 3-6 words | <input type="checkbox"/> Stacks two blocks |
| <input type="checkbox"/> Can point to a body part | <input type="checkbox"/> Feeds self with fingers |
| <input type="checkbox"/> Understands simple commands | <input type="checkbox"/> Drinks from cup |
| <input type="checkbox"/> Walks well | <input type="checkbox"/> Listens to story |
| <input type="checkbox"/> Stoops | <input type="checkbox"/> Tells what he/she wants by pulling, pointing, or grunting |
| <input type="checkbox"/> Climbs stairs | |

Date _____

Signature _____

18 Months

- | | |
|--|---|
| <input type="checkbox"/> Walks backward | <input type="checkbox"/> Listens to a story, looking at pictures and naming objects |
| <input type="checkbox"/> Throws ball | <input type="checkbox"/> Shows affection, kisses |
| <input type="checkbox"/> Says 15-20 words | <input type="checkbox"/> Follows simple directions |
| <input type="checkbox"/> Imitates words | <input type="checkbox"/> Points to some body parts |
| <input type="checkbox"/> Uses two-word phrases | <input type="checkbox"/> Scribbles |
| <input type="checkbox"/> Stacks three blocks | <input type="checkbox"/> Pulls a toy along the ground |
| <input type="checkbox"/> Uses a spoon and cup | |

Date _____

Signature _____

24 Months

- | | |
|---|---|
| <input type="checkbox"/> Goes up and down stairs one step at a time | <input type="checkbox"/> Uses at least 20 words, two-word phrases |
| <input type="checkbox"/> Kicks ball | <input type="checkbox"/> Follows two-step commands |
| <input type="checkbox"/> Stacks five blocks | <input type="checkbox"/> Imitates adults |

Date _____

Signature _____

3 Years

- | |
|---|
| <input type="checkbox"/> Jumps |
| <input type="checkbox"/> Kicks ball |
| <input type="checkbox"/> Rides tricycle |
| <input type="checkbox"/> Knows name, age, and sex |
| <input type="checkbox"/> Copies circle, cross |

Date _____

Signature _____

Reference: Bright Futures

Note: This resource is not a standardized, validated screening tool. However, it is acceptable until year 2003. (See Section III.c. for recommended standardized, validated screening tools, if desired.)

Developmental Milestones Checklist

CHILD'S NAME _____ DOB _____

4 Years

- | | |
|--|--|
| <input type="checkbox"/> Sings a song | <input type="checkbox"/> Builds 10 block tower |
| <input type="checkbox"/> Draws person with three parts | <input type="checkbox"/> Hops on one foot |
| <input type="checkbox"/> Distinguishes fantasy and reality | <input type="checkbox"/> Throws overhand ball |
| <input type="checkbox"/> Gives first and last name | |

Date _____

Signature _____

5 Years

- | | |
|--|---|
| <input type="checkbox"/> Dresses self without help | <input type="checkbox"/> Draws person with head, arms and legs |
| <input type="checkbox"/> Learns address and phone number | <input type="checkbox"/> Recognizes most letters and can print some |
| <input type="checkbox"/> Can count on fingers | <input type="checkbox"/> Plays make-believe |
| <input type="checkbox"/> Copies triangle or square | |

Date _____

Signature _____

6 Years

- | | |
|---|---|
| <input type="checkbox"/> Ties his/her own shoes | <input type="checkbox"/> Can tell age correctly |
| <input type="checkbox"/> Dresses self completely without help | <input type="checkbox"/> Repeats at least four numbers in a proper sequence |
| <input type="checkbox"/> Catches a small bouncing ball, such as a tennis ball, with only one hand | <input type="checkbox"/> Skips on both feet |

Date _____

Signature _____

7-10 Years

- | | |
|---|---|
| <input type="checkbox"/> School adjustment | <input type="checkbox"/> Friends |
| <input type="checkbox"/> School performance | <input type="checkbox"/> Activities outside of school |
| <input type="checkbox"/> Family | |

Date _____

Signature _____

11-21 Years

- | | |
|--|--|
| <input type="checkbox"/> Sexual development and behaviors (abstinence, STD prevention, BC) | <input type="checkbox"/> Emotional (Depression, Anxiety) |
| <input type="checkbox"/> Tobacco/Alcohol/Substance/Anabolic steroid use/avoidance | <input type="checkbox"/> School/Work problems |
| <input type="checkbox"/> Body image and dieting patterns | <input type="checkbox"/> Peer relationships |
| <input type="checkbox"/> Emotional, physical and sexual abuse | <input type="checkbox"/> Family relationships |

Date _____

Signature _____

Reference: Bright Futures

Note: This resource is not a standardized, validated screening tool. However, it is acceptable until year 2003. (See Section III c. for recommended standardized, validated screening tools, if desired).

Tuberculosis Risk Assessment Questionnaire

DATE _____ CHILD'S NAME _____ DOB _____
FILLED OUT BY _____

Any "Yes" answer means the child is high risk, and should receive a tuberculin skin test (Mantoux) which should be read by a health professional and the Public Health Department should be notified.

1. Is your child in close contact of a person with tuberculosis?
☐ Yes
☐ No
2. Is your child foreign born (esp. Asian, African, Latin American), a refugee or a migrant?
☐ Yes
☐ No
3. Does your child live in a community in which it has been established that a high risk exists for tuberculosis?
☐ Yes
☐ No
4. Does your child have a medical condition or treatment of a medical condition which suppresses the immune system?
☐ Yes
☐ No
5. Does your child have HIV infection or is he/she considered at risk for HIV infection?
☐ Yes
☐ No
6. Is your child exposed to the following individuals: HIV infected, homeless individuals, residents of nursing homes, institutionalized adolescents or adults, users of illicit drugs, incarcerated adolescents or adults or migrant farm workers?
☐ Yes
☐ No

Lead Risk Assessment Questionnaire

DATE _____ CHILD'S NAME _____ DOB _____
FILLED OUT BY _____

1. Does your child live in or regularly visit a house or child care facility built before 1960?
☐ Yes
☐ No
☐ Unknown
2. Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been renovated or remodeled (within the last 6 months)?
☐ Yes
☐ No
☐ Unknown
3. Have any of your children or any of their playmates had lead poisoning?
☐ Yes
☐ No
☐ Unknown

Additional Community-specific Questions

1. Does your home have plumbing with lead pipes or copper with lead solder joints?
☐ Yes
☐ No
☐ Unknown
2. Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?
☐ Yes
☐ No
☐ Unknown
3. Does your child frequently come in contact with an adult who works with lead (e.g., in construction, welding, potter, or other trades)?
☐ Yes
☐ No
☐ Unknown
4. Does your child live near a smelter, battery recycling plant, or other industrial site likely to release lead?
☐ Yes
☐ No
☐ Unknown
5. Do you give your child any home remedies that may contain lead?
☐ Yes
☐ No
☐ Unknown
6. Does your child eat paint chips or any non-food items or play in dirt in a yard where cars have been parked?
☐ Yes
☐ No
☐ Unknown

If any answer is yes, the child should have Blood Lead Level screening for possible lead toxicity.

2 Week Preventive Visit Form

DATE _____	NAME _____	DOB _____
Allergies: _____		
Meds: _____		

History

Physical Exam ✓=WNL, X=ABN
(Describe abnormal findings)

Screening ✓=WNL, X=ABN

Nutrition

- ☐ Breast _____ min _____ per day
☐ Formula _____ oz per day
 Type or brand _____
 With iron ☐ Yes ☐ No
☐ City water ☐ Well water
 WIC ☐ Yes ☐ No

Neonatal Metabolic Screen in Chart

- ☐ Yes ☐ No

Urine Output

- ☐ Normal ☐ Decreased
☐ Strong stream (If male)

Stools

- ☐ Normal ☐ Diarrhea _____ /day
☐ Hard _____ /day

Sleep

- ☐ Normal (2-4 hours)

New Symptoms/Problems/Complaints

Anticipatory Guidance Health Education (✓ if discussed)

Safety

- ☐ Car seat
☐ Smoke-free environment
☐ Smoke detectors
☐ Crib safety
☐ Baths
☐ Water temperature <120°
☐ Child proof home

Nutrition

- ☐ Increase formula
☐ Breast or iron-fortified formula
☐ Infant weight gain
☐ Colic crying

Health

- ☐ Sleep on back
☐ Know signs of illness
☐ Thermometer use, antipyretics
☐ Emergency procedures
☐ No bottle in bed
☐ Bowel movements
☐ Cord, circumcision care

Social/Behavior

- ☐ Baby's temperament
☐ Console baby, hold, cuddle, rock, talk, sing
☐ Encourage partner to care for infant
☐ Support from family/friends
☐ Postpartum check-up
☐ Child care

Ht _____ in _____ %tile
 Wt _____ lbs _____ oz _____ %tile
 Head Circumference _____ cm _____ %tile
 (See chart on separate page)

Patient Unclothed ☐ Yes ☐ No

☐ General Appearance _____

☐ Head _____

☐ Eyes _____

☐ Ears _____

☐ Nose _____

☐ Oropharynx _____

☐ Gums/Palate _____

☐ Neck _____

☐ Lungs _____

☐ Heart _____

☐ Abdomen _____

☐ Genitalia _____

☐ Extremities/Hips _____

☐ Spine _____

☐ Neurological _____

☐ Skin/Nodes _____

☐ Other _____

Hearing

- ☐ Responds to sounds
☐ Neonatal ABR or OAE results in chart

Impression

- ☐ Well infant
☐ Normal growth
☐ Normal development
☐ Other

Plan

- ☐ Family history, birth history
☐ Newborn metabolic screen
 ☐ Normal ☐ Pending ☐ Today
☐ RTC for 2 month well check
☐ Referrals
 ☐ WIC
 ☐ Transportation
 ☐ Other referrals _____

☐ Other _____

Sign _____

- ☐ Additional documentation on back
☐ Additional documentation on separate page

2 Month Preventive Visit Form

DATE _____ NAME _____ DOB _____
 Allergies: _____
 Meds: _____

History

Physical Exam ✓=WNL, X=ABN
 (Describe abnormal findings)

Screening ✓=WNL, X=ABN

Nutrition

- ☐ Breast _____ min _____ per day
☐ Formula _____ oz per day
 Type or brand _____
 With iron ☐ Yes ☐ No
☐ City water ☐ Well water
 WIC ☐ Yes ☐ No

Neonatal Metabolic Screen In Chart

- ☐ Yes ☐ No

Urine Output

- ☐ Normal ☐ Decreased
☐ Strong stream (If male)

Stools

- ☐ Normal ☐ Diarrhea _____/day
☐ Hard _____/day

Sleep

- ☐ Normal (4 hours)

New Symptoms/Problems/Complaints

Anticipatory Guidance Health
 Education (✓ if discussed)

Safety

- ☐ Car seat
☐ Smoke-free environment
☐ Smoke detectors
☐ Crib safety
☐ Child proof home
☐ Small and sharp objects; plastic bags
☐ Water temperature <120°

Nutrition

- ☐ Increase formula
☐ Delay solid foods
☐ Breastfeed or iron-fortified formula
☐ Colic crying

Health

- ☐ Know signs of illness
☐ Thermometer use; antipyretics
☐ Bowel movements
☐ Emergency procedures
☐ No bottle in bed
☐ Sleep on back

Social/Behavior

- ☐ Baby's temperament
☐ Hold, cuddle, rock
☐ Talk, sing, read, play music
☐ Partner and sibling involvement
☐ Time for self and partner
☐ Play and parent support groups

Ht _____ in _____ %tile
 Wt _____ lbs _____ oz _____ %tile
 Head Circumference _____ cm _____ %tile
 (See chart on separate page)

Patient Unclothed ☐ Yes ☐ No

☐ General Appearance _____

☐ Head _____

☐ Eyes _____

☐ Ears _____

☐ Nose _____

☐ Oropharynx _____

☐ Gums/Palate _____

☐ Neck _____

☐ Lungs _____

☐ Heart _____

☐ Abdomen _____

☐ Genitalia _____

☐ Extremities/Hips _____

☐ Spine _____

☐ Neurological _____

☐ Skin/Nodes _____

☐ Other _____

Developmental/Behavioral Screen

- ☐ WNL (See separate page)
☐ ABN

Vision

- ☐ Parental observation/concerns
☐ Fixes and follows

Hearing

- ☐ Parental observations/concerns
☐ Family history
☐ Neonatal ABR or OAE results in chart

Impression

- ☐ Well infant
☐ Normal growth
☐ Normal development
☐ Other _____

Plan

- ☐ History updated
☐ Problem list, allergies, medication list updated
☐ Immunizations
☐ Up to date
☐ Info read and discussed
☐ DTaP/DTIP ☐ IPV ☐ HBV ☐ Hib
☐ Acetaminophen _____ mg q 4 hours
☐ Newborn metabolic screen
☐ Normal ☐ Pending ☐ Today
☐ Handouts given (2 Mo.)
☐ RTC for 4 month well check
☐ Referrals
☐ WIC
☐ Transportation
☐ Other referrals _____

☐ Other _____

- ☐ Additional documentation on back
☐ Additional documentation on separate page

Sign _____

4 Month Preventive Visit Form

DATE _____ NAME _____ DOB _____
 Allergies: _____
 Meds: _____

History

Physical Exam ✓=WNL, X=ABN (Describe abnormal findings)

Screening ✓=WNL, X=ABN

Nutrition

- ☐ Breast _____ min _____ per day
☐ Formula _____ oz per day
 Type or brand _____
 With iron ☐ Yes ☐ No
☐ City water ☐ Well water
 WIC ☐ Yes ☐ No

Neonatal Metabolic Screen in Chart

- ☐ Yes ☐ No

Urine Output

- ☐ Normal ☐ Decreased

Stools

- ☐ Normal ☐ Diarrhea _____/day
☐ Hard _____/day

Sleep

- ☐ Normal (4-6 hours)

New Symptoms/Problems/Complaints

Safety

Anticipatory Guidance Health Education (✓ if discussed)

- ☐ Car seat
☐ Water temperature <120°
☐ Smoke-free environment
☐ Smoke detectors
☐ Child proof home
☐ No baby walker

Nutrition

- ☐ Breastfeed or iron-fortified formula
☐ Introduce solid food
☐ Avoid honey

Health

- ☐ Know signs of illness
☐ Sleep on back
☐ Syrup of Ipecac

Social/Behavior

- ☐ Hold, cuddle, rock
☐ Talk, sing, play music
☐ Partner and sibling involvement
☐ Community involvement
☐ Bedtime routine

Ht _____ in _____ %tile
 Wt _____ lbs _____ oz _____ %tile
 Head Circumference _____ cm _____ %tile
 (See chart on separate page)

Patient Unclothed ☐ Yes ☐ No

☐ General Appearance _____

☐ Head _____

☐ Eyes _____

☐ Ears _____

☐ Nose _____

☐ Oropharynx _____

☐ Gums/Palate _____

☐ Neck _____

☐ Lungs _____

☐ Heart _____

☐ Abdomen _____

☐ Genitalia _____

☐ Extremities/Hips _____

☐ Spine _____

☐ Neurological _____

☐ Skin/Nodes _____

☐ Other _____

Developmental/Behavioral Screen

- ☐ WNL (See separate page)
☐ ABN

Vision

- ☐ Parental observation/concerns
☐ Fixes and follows

Hearing

- ☐ Parental observations/concerns
☐ Responds to sound (parent report)
☐ Responds to noisemaker (optional)

Impression

- ☐ Well infant
☐ Normal growth
☐ Normal development
☐ Other _____

Plan

- ☐ History updated
☐ Problem list, allergies, medication list updated
☐ Immunizations
☐ Up to date
☐ Info read and discussed
☐ DTaP/DIP ☐ IPV ☐ HBV ☐ Hib
☐ Acetaminophen _____ mg q 4 hours
☐ Handouts given (4 Mo.)
☐ RTC for 6 month well check
☐ Referrals
☐ WIC
☐ Transportation
☐ Other referrals _____

☐ Other _____

- ☐ Additional documentation on back
☐ Additional documentation on separate page

Sign _____

6 Month Preventive Visit Form

DATE _____ NAME _____ DOB _____
 Allergies: _____
 Meds: _____

History

Physical Exam ✓=WNL, X=ABN
 (Describe abnormal findings)

Screening ✓=WNL, X=ABN

Nutrition

- ☐ Breast _____ min _____ per day
☐ Formula _____ oz per day
 Type or brand _____
 With iron ☐ Yes ☐ No
☐ City water ☐ Well water
 WIC ☐ Yes ☐ No

Neonatal Metabolic Screen in Chart

- ☐ Yes ☐ No

Urine Output

- ☐ Normal ☐ Decreased

Stools

- ☐ Normal ☐ Diarrhea _____/day
☐ Hard _____/day

Sleep

- ☐ Normal (6-8 hours)

New Symptoms/Problems/Complaints

Anticipatory Guidance Health
 Education (✓ if discussed)

Safety

- ☐ Check hazards
☐ Car seat
☐ Smoke-free environment
☐ Smoke detectors
☐ Child proof home
☐ No baby walker

Nutrition

- ☐ Breastfeed or iron-fortified formula
☐ Start cup for water, juice
☐ Supervise eating
☐ Avoid choke foods
☐ Avoid honey

Health

- ☐ Fluoride
☐ Brush teeth
☐ Syrup of Ipecac
☐ No bottle in bed

Social/Behavior

- ☐ Exploration opportunities
☐ Talk, sing, read, play music
☐ Pat-a-cake, peek-a-boo
☐ Limit but enforce rules
☐ Bedtime routine
☐ Contact with friends, family
☐ Use distraction as discipline

Ht _____ in _____ %tile
 Wt _____ lbs _____ oz _____ %tile
 Head Circumference _____ cm _____ %tile
 (See chart on separate page)

Patient Unclothed ☐ Yes ☐ No

☐ General Appearance _____

☐ Head _____

☐ Eyes _____

☐ Ears _____

☐ Nose _____

☐ Oropharynx _____

☐ Gums/Palate _____

☐ Neck _____

☐ Lungs _____

☐ Heart _____

☐ Abdomen _____

☐ Genitalia _____

☐ Extremities/Hips _____

☐ Spine _____

☐ Neurological _____

☐ Skin/Nodes _____

☐ Other _____

Developmental/Behavioral Screen

- ☐ WNL (See separate page)
☐ ABN

Vision

- ☐ Parental observation/concerns
☐ Fixes and follows

Hearing

- ☐ Parental observations/concerns
☐ Responds to voice and noise
 (parent report)
☐ Responds to noisemaker (optional)

Impression

- ☐ Well child
☐ Normal growth
☐ Normal development
☐ Risk assessment for lead exposure
☐ Other

Plan

- ☐ History updated
☐ Problem list, allergies, medication list updated
☐ Immunizations
☐ Up to date
☐ Info read and discussed
☐ DTaP/DTP ☐ IPV ☐ HBV ☐ Hib
☐ No adverse reactions to prior imm.
☐ Lead level _____ mcg/dl
☐ Acetaminophen _____ mg q 4 hours
☐ Handouts given (6 Mo.)
☐ RTC for 9 month well check
☐ Referrals
☐ WIC
☐ Transportation
☐ Other referrals _____

☐ Other _____

- ☐ Additional documentation on back
☐ Additional documentation on separate page

Sign _____

9 Month Preventive Visit Form

DATE _____ NAME _____ DOB _____
 Allergies: _____
 Meds: _____

History

Nutrition

- ☐ Breast _____ min _____ per day
☐ Formula _____ oz per day
 Type or brand _____
 With iron ☐ Yes ☐ No
☐ City water ☐ Well water
 WIC ☐ Yes ☐ No

Neonatal Metabolic Screen In Chart

- ☐ Yes ☐ No

Urine Output

- ☐ Normal ☐ Decreased

Stools

- ☐ Normal ☐ Diarrhea _____/day
☐ Hard _____/day

Sleep

- ☐ Normal (8 hours)

New Symptoms/Problems/Complaints

Anticipatory Guidance Health Education (✓ if discussed)

Safety

- ☐ Check hazards
☐ Smoke-free environment
☐ No baby walker
☐ Child proof home
☐ Assess lead risk
☐ Car seat
☐ Empty buckets

Nutrition

- ☐ Breastfeed or iron-fortified formula
☐ Finger foods, mashed food
☐ Avoid choke foods
☐ Supervise eating
☐ Drink from a cup

Health

- ☐ Brush teeth
☐ Fluoride
☐ Water temperature <120°
☐ No bottle in bed

Social/Behavior

- ☐ Partner and sibling involvement
☐ Talk, sing
☐ Pat-a-cake, peek-a-boo
☐ Bedtime routine
☐ Exploration opportunities
☐ Limit but enforce rules
☐ Role model healthy habits

Physical Exam ✓=WNL, X=ABN (Describe abnormal findings)

Ht _____ in _____ %tile
 Wt _____ lbs _____ oz _____ %tile
 Head Circumference _____ cm _____ %tile
 (See chart on separate page)

Patient Unclothed ☐ Yes ☐ No

☐ General Appearance _____

☐ Head _____

☐ Eyes _____

☐ Ears _____

☐ Nose _____

☐ Oropharynx _____

☐ Gums/Palate _____

☐ Neck _____

☐ Lungs _____

☐ Heart _____

☐ Abdomen _____

☐ Genitalia _____

☐ Extremities/Hips _____

☐ Spine _____

☐ Neurological _____

☐ Skin/Nodes _____

☐ Other _____

Screening ✓=WNL, X=ABN

Developmental/Behavioral Screen

- ☐ WNL
☐ ABN (See separate page)

Vision

- ☐ Parental observation/concerns
☐ Fixes and follows

Hearing

- ☐ Parental observations/concerns
☐ Responds to voice and noise
 (parent report)
☐ Responds to noisemaker (optional)

Impression

- ☐ Well child
☐ Normal growth
☐ Normal development
☐ Risk assessment for lead exposure
☐ Other

Plan

- ☐ History updated
☐ Problem list, allergies, medication list updated
☐ Immunizations
☐ Up to date
☐ Info read and discussed
☐ No adverse reactions to prior imm.
☐ HBV ☐ Other _____
☐ Hct or Hgb _____
☐ Lead level _____ mcg/dl
☐ Acetaminophen _____ mg q 4 hours
☐ IPPD _____ (result)
☐ Handouts given (9 Mo.)
☐ RTC for 12 month well check
☐ Referrals
☐ WIC
☐ Transportation
☐ Other referrals _____

☐ Other _____

- ☐ Additional documentation on back
☐ Additional documentation on separate page

Sign _____

12 Month Preventive Visit Form

DATE _____ NAME _____ DOB _____
 Allergies: _____
 Meds: _____

History

Nutrition

- ☐ Breast _____ min _____ per day
☐ Formula _____ oz per day
 Type or brand _____
 With iron ☐ Yes ☐ No
☐ City water ☐ Well water
 WIC ☐ Yes ☐ No

Neonatal Metabolic Screen In Chart

- ☐ Yes ☐ No

Urine Output

- ☐ Normal ☐ Decreased

Stools

- ☐ Normal ☐ Diarrhea _____/day
☐ Hard _____/day

Sleep

- ☐ Normal (8-12 hours)

New Symptoms/Problems/Complaints

Anticipatory Guidance Health Education (✓ if discussed)

Safety

- ☐ Toddler car seat/ Airbags
☐ Smoke-free environment
☐ Lower crib mattress
☐ Close supervision
☐ Water safety
☐ Childproof home

Nutrition

- ☐ Whole milk, drink from cup
☐ Healthy food choices, experimentation
☐ Weaning from bottle
☐ Ad lib breast feeding
☐ Limit juice to < 8 oz.

Health

- ☐ Brush teeth
☐ First dental exam
☐ Poison, Ipecac use, Poison Control
☐ Proper use of phone/ER

Social/Behavior

- ☐ Cuddling, holding, affection
☐ Established routines
☐ Hitting, biting, aggressive behavior
☐ Praise toddler
☐ Interactive talking, singing, reading
☐ Limited number of caregivers

Physical Exam ✓=WNL, X=ABN (Describe abnormal findings)

Ht _____ in _____ %tile
 Wt _____ lbs _____ oz _____ %tile
 Head Circumference _____ cm _____ %tile
 (See chart on separate page)

Patient Unclothed ☐ Yes ☐ No

☐ General Appearance _____

☐ Head _____

☐ Eyes _____

☐ Ears _____

☐ Nose _____

☐ Oropharynx _____

☐ Gums/Palate _____

☐ Neck _____

☐ Lungs _____

☐ Heart _____

☐ Abdomen _____

☐ Genitalia _____

☐ Extremities/hips _____

☐ Spine _____

☐ Neurological _____

☐ Skin/Nodes _____

☐ Other _____

Screening ✓=WNL, X=ABN

Developmental/Behavioral Screen

- ☐ WNL (See separate page)
☐ ABN (See separate page)

Vision

- ☐ Parental observation/concerns
☐ Fixes and follows

Hearing

- ☐ Parental observations/concerns
☐ Responds to voice and noise
 (parent report)
☐ Responds to noisemaker (optional)

Impression

- ☐ Well child
☐ Normal growth
☐ Normal development
☐ Low risk for lead exposure
☐ Low risk for tuberculosis
☐ Other

Plan

- ☐ History updated
☐ Problem list, allergies, medication list updated
☐ Immunizations
☐ Up to date
☐ Info read and discussed
☐ No adverse reactions to prior imm.
☐ HBV ☐ Varicella
☐ Other _____
☐ Hct or Hgb _____
☐ Lead level _____ mcg/dl
☐ Acetaminophen _____ mg q 4 hours
☐ IPPD _____ (result)
☐ Handouts given (12 Mo.)
☐ RTC for 15-18 month well check
☐ Referrals
☐ WIC
☐ Transportation
☐ Other referrals _____
☐ Other _____

- ☐ Additional documentation on back
☐ Additional documentation on separate page

Sign _____

15-18 Month Preventive Visit Form

DATE _____ NAME _____ DOB _____
 Allergies: _____
 Meds: _____

History

Nutrition

- ☐ Whole milk, cup only
- ☐ Solids (serv/day)
 - ____ Meat/Egg
 - ____ Veg/Fruit
 - ____ Bread/Cereal
 - ☐ other _____
- ☐ City water ☐ Well water ☐ Bottled water
- WIC ☐ Yes ☐ No

Urine Output

- ☐ Normal ☐ Decreased

Stools

- ☐ Normal ☐ Diarrhea ____/day
- ☐ Hard ____/day

Sleep

- ☐ Normal (8-12 hours)
- ☐ Abnormal

New Symptoms/Problems/Complaints

Anticipatory Guidance Health Education (✓ if discussed)

Safety

- ☐ Car seat/ Airbags
- ☐ Crib safety/ Crib mattress lowered
- ☐ Childproof home
- ☐ Window guards
- ☐ Smoke-free environment
- ☐ Choke foods

Nutrition

- ☐ Wean from bottle
- ☐ Safe table foods
- ☐ Healthy food choices/ No forced foods
- ☐ Self-feeding/ Drinking from cup
- ☐ Family meals

Health

- ☐ Brush teeth
- ☐ Proper use of phone/ER

Social/Behavior

- ☐ Individual attention
- ☐ Exploration/ Physical activity
- ☐ Hitting, biting, aggressive behavior
- ☐ Enforce rules/ Reassure once negative behavior stops
- ☐ Family playtime
- ☐ Help toddler express anger/joy
- ☐ Short family outings
- ☐ Older children
- ☐ Toilet training
- ☐ Community Programs/ Preschool
- ☐ Peek-A-Boo/Pat-A-Cake

Physical Exam ✓=WNL, X=ABN (Describe abnormal findings)

Ht _____ in _____ %tile
 Wt _____ lbs _____ oz _____ %tile
 Head Circumference _____ cm _____ %tile
 (See chart on separate page)

Patient Unclothed ☐ Yes ☐ No

☐ General Appearance _____

☐ Head _____

☐ Eyes _____

☐ Ears _____

☐ Nose _____

☐ Oropharynx _____

☐ Gums/Palate _____

☐ Neck _____

☐ Lungs _____

☐ Heart _____

☐ Abdomen _____

☐ Genitalia _____

☐ Extremities/Hips _____

☐ Spine _____

☐ Neurological _____

☐ Skin/Nodes _____

☐ Other _____

Screening ✓=WNL, X=ABN

Developmental/Behavioral Screen

- ☐ WNL (See separate page)
- ☐ ABN

Vision

- ☐ Parental observation/concerns
- ☐ Can see small objects

Hearing

- ☐ Parental observations/concerns
- ☐ Responds to voice and noise (parent report)
- ☐ Responds to noisemaker (optional)

Impression

- ☐ Well child
- ☐ Normal growth
- ☐ Normal development
- ☐ Low risk for lead exposure
- ☐ Low risk for tuberculosis
- ☐ Other _____

Plan

- ☐ History updated
- ☐ Problem list, allergies, medication list updated
- ☐ Immunizations
 - ☐ Up to date
 - ☐ Info read and discussed
 - ☐ No adverse reactions to prior imm.
 - ☐ DTaP/DTP ☐ Hib ☐ MMR
- ☐ Hct or Hgb _____
- ☐ Referrals
 - ☐ WIC
 - ☐ Transportation
 - ☐ Other referrals _____
- ☐ Other _____

- ☐ Additional documentation on back
- ☐ Additional documentation on separate page

Sign _____

24 Month Preventive Visit Form

DATE _____ NAME _____ DOB _____
 Allergies: _____
 Meds: _____

History

Nutrition

- ☐ Whole milk, cup only
☐ Solids (serv/day)
 ____ Meat/Egg
 ____ Veg/Fruit
 ____ Bread/Cereal
☐ other _____
☐ City water ☐ Well water ☐ Bottled water
 WIC ☐ Yes ☐ No

Urine Output

- ☐ Normal ☐ Decreased

Stools

- ☐ Normal ☐ Diarrhea ____/day
☐ Hard ____/day

Sleep

- ☐ Normal (8-12 hours)
☐ Abnormal

New Symptoms/Problems/Complaints

Anticipatory Guidance Health Education (✓ if discussed)

Safety

- ☐ Car seat
☐ Poisons, Ipecac use, Poison control
☐ Smoking exposure, Alarms
☐ Close supervision

Nutrition

- ☐ Variety/ Safe table foods
☐ No forced foods

Health

- ☐ Brush teeth
☐ Proper use of phone/ER

Social/Behavior

- ☐ Parental interaction/Talk/Sing
☐ Self-care/Self quieting
☐ Exploration/Physical activity
☐ Choices/Limits/Time out
☐ Toilet training

Physical Exam ✓=WNL, X=ABN (Describe abnormal findings)

Ht _____ in _____ %tile
 Wt _____ lbs _____ oz _____ %tile
 Head Circumference _____ cm _____ %tile
 (See chart on separate page)

Patient Unclothed ☐ Yes ☐ No

☐ General Appearance _____

☐ Head _____

☐ Eyes _____

☐ Ears _____

☐ Nose _____

☐ Oropharynx _____

☐ Gums/Palate _____

☐ Neck _____

☐ Lungs _____

☐ Heart _____

☐ Abdomen _____

☐ Genitalia _____

☐ Extremities/Hips _____

☐ Spine _____

☐ Neurological _____

☐ Skin/Nodes _____

☐ Other _____

Screening ✓=WNL, X=ABN

Developmental/Behavioral Screen

- ☐ WNL (See separate page)
☐ ABN

Vision

- ☐ Parental observation/concerns
☐ Can see small objects

Hearing

- ☐ Parental observations/concerns
☐ Responds to voice and noise
 (parent report)
☐ Responds to noisemaker (optional)

Impression

- ☐ Well child
☐ Normal growth
☐ Normal development
☐ Low risk for lead exposure
☐ Low risk for tuberculosis
☐ Other _____

Plan

- ☐ History updated
☐ Problem list, allergies, medication list updated
☐ Immunizations
 ☐ Up to date
 ☐ Info read and discussed
 ☐ No adverse reactions to prior imm.
 ☐ DTaP/DTP ☐ IPV ☐ Hib
 ☐ HBV ☐ MMR
☐ Hct or Hgb _____
☐ Other _____
☐ Acetaminophen _____ mg q 4 hours
☐ Handouts given (discipline, toilet training)
☐ RTC for 3 year well check
☐ Referrals
 ☐ WIC
 ☐ Transportation
 ☐ Other referrals _____
☐ Other _____

- ☐ Additional documentation on back
☐ Additional documentation on separate page

Sign _____

3 Year Preventive Visit Form

DATE _____ NAME _____ DOB _____
 Allergies: _____
 Meds: _____

History

Physical Exam ✓=WNL, X=ABN
 (Describe abnormal findings)

Screening ✓=WNL, X=ABN

Nutrition

- ☐ Food (serv/day)
 _____ Meat/Egg
 _____ Veg/Fruit
 _____ Bread/Cereal
 ☐ other _____
☐ City water ☐ Well water ☐ Bottled water
 WIC ☐ Yes ☐ No

Urine Output

- ☐ Normal ☐ Decreased

Stools

- ☐ Normal ☐ Diarrhea _____/day
☐ Hard _____/day

Sleep

- ☐ Normal (8-12 hours)
☐ Abnormal

New Symptoms/Problems/Complaints

Anticipatory Guidance Health
 Education (✓ if discussed)

Safety

- ☐ Playground/Stranger
☐ Seatbelts/Booster seats
☐ Fires/Burns

Nutrition

- ☐ See Dentist/ Brush teeth
☐ Family meals
☐ Variety/Low fat/Limit sweets

Social/Behavior

- ☐ Exploration/ Physical activity
☐ Socialization
☐ Praise/ Talking/ Interactive reading
☐ Sibling relationships
☐ Limit TV

Ht _____ in _____ %tile
 Wt _____ lbs _____ oz _____ %tile
 (See chart on separate page)

Patient Unclothed ☐ Yes ☐ No

☐ General Appearance _____

☐ Head _____

☐ Eyes _____

☐ Ears _____

☐ Nose _____

☐ Oropharynx _____

☐ Gums/Palate _____

☐ Neck _____

☐ Lungs _____

☐ Heart _____

☐ Abdomen _____

☐ Genitalia _____

☐ Extremities/Hips _____

☐ Spine _____

☐ Neurological _____

☐ Skin/Nodes _____

☐ Other _____

Developmental/Behavioral Screen

- ☐ WNL (See separate page)
☐ ABN

Vision

- ☐ Parental observation/concerns
☐ Can see small objects
☐ Ocular alignment
☐ Visual acuity (optional)
 _____ R _____ L _____ Both

Hearing

- ☐ Parental observations/concerns
☐ Screening audiometry (optional)
☐ Screening with noisemaker (optional)

Impression

- ☐ Well child
☐ Normal growth
☐ Normal development
☐ Low risk for lead exposure
☐ Low risk for tuberculosis
☐ Low risk for hyperlipidemia

Plan

- ☐ History updated
☐ Problem list, allergies, medication list updated
☐ Immunizations
 ☐ Up to date
 ☐ Info read and discussed
 ☐ No adverse reactions to prior imm.
☐ Het or High _____
☐ Acetaminophen _____ mg q 4 hours
☐ Handouts given (3 year)
☐ Urinalysis
☐ RTC for 4 year well check
☐ Referrals
 ☐ WIC
 ☐ Transportation
 ☐ Dental
 ☐ Other referrals _____
☐ Other _____

- ☐ Additional documentation on back
☐ Additional documentation on separate page

Sign _____

4 Year Preventive Visit Form

DATE _____ NAME _____ DOB _____
 Allergies: _____
 Meds: _____

History

Nutrition

- ☐ Food (serv/day)
 ___ Meat/Egg
 ___ Veg/Fruit
 ___ Bread/Cereal
 ☐ other _____
☐ City water ☐ Well water ☐ Bottled water
 WIC ☐ Yes ☐ No

Urine Output

- ☐ Normal ☐ Decreased

Stools

- ☐ Normal ☐ Diarrhea ___/day
☐ Hard ___/day

Sleep

- ☐ Normal (8-12 hours)
☐ Abnormal

New Symptoms/Problems/Complaints

Anticipatory Guidance Health Education (✓ if discussed)

Safety

- ☐ Smoking exposure/Alarms
☐ Bike helmet
☐ Safety/Water/Playground/Stranger

Nutrition

- ☐ Variety/Low fat/Limit sweets
☐ Sucking habits

Health

- ☐ Sexuality

Social/Behavior

- ☐ Rules for behavior
☐ Listen/Respect/Interest in activities
☐ Household duties/Responsibilities
☐ After-school child care
☐ Limits/Time out

Physical Exam ✓=WNL, X=ABN (Describe abnormal findings)

Ht _____ in _____ %tile
 Wt _____ lbs _____ oz _____ %tile
 (See chart on separate page)

Patient Unclothed ☐ Yes ☐ No

- ☐ General Appearance _____
☐ Head _____
☐ Eyes _____
☐ Ears _____
☐ Nose _____
☐ Oropharynx _____
☐ Gums/Palate _____
☐ Neck _____
☐ Lungs _____
☐ Heart _____
☐ Abdomen _____
☐ Genitalia _____
☐ Extremities/hips _____
☐ Spine _____
☐ Neurological _____
☐ Skin/Nodes _____
☐ Other _____

Screening ✓=WNL, X=ABN

Developmental/Behavioral Screen

- ☐ WNL (See separate page)
☐ ABN

Vision

- ☐ Parental observation/concerns
☐ Can see small objects
☐ Ocular alignment
☐ Visual acuity
 R _____ L _____ Both _____

Hearing

- ☐ Parental observations/concerns
☐ Screening audiometry, if not done
 at 3 years

Impression

- ☐ Well child
☐ Normal growth
☐ Normal development
☐ Low risk for lead exposure
☐ Low risk for tuberculosis
☐ Low risk for hyperlipidemia
☐ Other _____

Plan

- ☐ History updated
☐ Problem list, allergies, medication list updated
☐ Immunizations
 ☐ Up to date
 ☐ No adverse reactions to prior imm.
☐ Hct or Hgb _____
☐ Urinalysis
☐ RTC for 5 year well check
☐ Referrals
 ☐ WIC
 ☐ Transportation
 ☐ Dental
 ☐ Other referrals _____
☐ Other _____

- ☐ Additional documentation on back
☐ Additional documentation on separate page

Sign _____

5 Year Preventive Visit Form

DATE _____ NAME _____ DOB _____
 Allergies: _____
 Meds: _____

History

Physical Exam ✓=WNL, X=ABN (Describe abnormal findings)

Screening ✓=WNL, X=ABN

Nutrition

- ☐ Food (serv/day)
 _____ Meat/Egg
 _____ Veg/Fruit
 _____ Bread/Cereal
 _____ Milk/Dairy
☐ other _____
☐ City water ☐ Well water ☐ Bottled water
 WIC ☐ Yes ☐ No

Urine Output

- ☐ Normal ☐ Decreased

Stools

- ☐ Normal ☐ Diarrhea _____/day
☐ Hard _____/day

Sleep

- ☐ Abnormal

New Symptoms/Problems/Complaints

Anticipatory Guidance Health Education (✓ if discussed)

Safety

- ☐ Pedestrian/Playground/Stranger
☐ Car seat/Seat belt/Bike Helmet

Nutrition

- ☐ Healthy meals and snacks
☐ Dental sealants
☐ Family meals

Health

- ☐ Adequate sleep/Physical activity
☐ Tooth care/Dental exams
☐ Curiosity about sex

Social/Behavior

- ☐ Family Rules/Respect/Right from wrong
☐ Praise/Encourage
☐ Handle anger/Conflict resolution
☐ Prepare child for school
☐ Tour school/Meet teachers
☐ Affection

Ht _____ in _____ %tile
 Wt _____ lbs _____ oz _____ %tile
 (See chart on separate page)

Patient Unclothed ☐ Yes ☐ No

☐ General Appearance _____

☐ Head _____

☐ Eyes _____

☐ Ears _____

☐ Nose _____

☐ Oropharynx _____

☐ Gums/Palate _____

☐ Neck _____

☐ Lungs _____

☐ Heart _____

☐ Abdomen _____

☐ Genitalia _____

☐ Extremities/Hips _____

☐ Spine _____

☐ Neurological _____

☐ Skin/Nodes _____

☐ Other _____

Developmental/Behavioral Screen

- ☐ WNL (See separate page)
☐ ABN

Vision

- ☐ Parental observation/concerns
☐ Can see small objects
☐ Ocular alignment
☐ Visual acuity (optional)
 _____ R _____ L _____ Both

Hearing

- ☐ Parental observations/concerns
☐ Screening audiometry, if not done
 at 3 or 4 years

Impression

- ☐ Well child
☐ Normal growth
☐ Normal development
☐ Low risk for lead exposure
☐ Low risk for tuberculosis
☐ Low risk for hyperlipidemia
☐ Other

Plan

- ☐ History updated
☐ Problem list, allergies, medication list updated
☐ Immunizations
☐ Up to date
☐ Info read and discussed
☐ No adverse reactions to prior immun
☐ DTaP/DTP ☐ IPV ☐ HBV ☐ MMR
☐ Other _____
☐ Hct or Hgb _____
☐ UA
☐ IPPD
☐ Lead level _____ mcg/dl
☐ Urinalysis
☐ RTC for 6 year well check
☐ Referrals
☐ Transportation
☐ Dental
☐ Other referrals _____
☐ Other _____

- ☐ Additional documentation on back
☐ Additional documentation on separate page

Sign _____

6-10 Year Preventive Visit Form

DATE _____ NAME _____ DOB _____
 Allergies: _____
 Meds: _____

History

Physical Exam ✓=WNL, X=ABN
 (Describe abnormal findings)

Screening ✓=WNL, X=ABN

Nutrition

- ☐ Food (serv/day)
 ___ Meat/Egg
 ___ Veg/Fruit
 ___ Bread/Cereal
 ___ Milk/Dairy
 ☐ other _____
☐ City water ☐ Well water ☐ Bottled water

Urine Output

- ☐ Normal ☐ Decreased

Stools

- ☐ Normal ☐ Diarrhea ___/day
☐ Hard ___/day

Sleep

- ☐ Normal (8-12 hours)
☐ Abnormal

New Symptoms/Problems/Complaints

Anticipatory Guidance Health Education (✓ if discussed)

Safety

- ☐ Seatbelts/Bike helmet/Water/
 Neighborhood/ Sports
☐ Matches/Poisons/Guns
☐ Dental emergency care
☐ Drugs/Alcohol/Tobacco

Nutrition

- ☐ Food choices (Fruits, Veg, Grains)
☐ Adequate Calcium

Health

- ☐ Adequate sleep/Exercise/
 Physical activity
☐ Personal space
☐ Puberty/Sexual development
☐ Personal hygiene

Social/Behavior

- ☐ Limit TV
☐ Self discipline
☐ Chores
☐ Reading/Hobbies/Talents
☐ Community and school programs
☐ Positive interactions with adults
☐ Know child's friends/families
☐ Reasonable expectations
☐ Time out restrictions/Rewards

Ht _____ in _____ %tile
 Wt _____ lbs _____ oz _____ %tile
 (See chart on separate page)

Patient Unclothed ☐ Yes ☐ No

☐ General Appearance _____

☐ Head _____

☐ Eyes _____

☐ Ears _____

☐ Nose _____

☐ Oropharynx _____

☐ Gums/Palate _____

☐ Neck _____

☐ Lungs _____

☐ Heart _____

☐ Abdomen _____

☐ Genitalia _____

☐ Extremities/Thips _____

☐ Spine _____

☐ Neurological _____

☐ Skin/Nodes _____

☐ Other _____

- ☐ Additional documentation on back
☐ Additional documentation on separate page

Developmental/Behavioral Screen

- ☐ WNL
☐ ABN (See separate page)

Vision

- ☐ Parental observation/concerns
☐ Visual acuity
 ___ R ___ L ___ Both

Hearing

- ☐ Parental observations/concerns
☐ Screening audiometry, if not done
 previously

Impression

- ☐ Well child
☐ Normal growth
☐ Tanner Stage _____
☐ Normal development
☐ Low risk for tuberculosis
☐ Low risk for hyperlipidemia
☐ Other _____

Plan

- ☐ History updated
☐ Problem list, allergies, medication list
 updated
☐ Immunizations
 ☐ Up to date
 ☐ Info read and discussed
 ☐ No adverse reactions to prior imm.
 ☐ Td ☐ IPV ☐ HBV
 ☐ MMR ☐ Varivax
☐ Other _____
☐ Hct or Hgb _____
☐ UA
☐ IPPD
☐ School Forms completed
☐ Urinalysis
☐ RTC for well check in _____ yr
☐ Referrals
 ☐ Transportation
 ☐ Dental
 ☐ Other referrals _____
☐ Other _____

Sign _____

10-14 Year Preventive Visit Form

DATE _____ NAME _____ DOB _____

Allergies: _____

Meds: _____

History

Nutrition

- ☐ Food (serv/day)
 ____ Meat/Egg
 ____ Veg/Fruit
 ____ Bread/Cereal
 ____ Milk/Dairy
☐ other _____
☐ City water ☐ Well water ☐ Bottled water

Urine Output

- ☐ Normal ☐ Decreased

Stools

- ☐ Normal ☐ Diarrhea ____/day
☐ Hard ____/day

Sleep

- ☐ Normal (8-12 hours)
☐ Abnormal

Menstrual

- ☐ Premenarchal
☐ Normal
☐ Abnormal

New Symptoms/Problems/Complaints

Anticipatory Guidance Health Education (✓ if discussed)

Safety

- ☐ Seatbelts/Helmets/Sunscreen
☐ Weapons

Nutrition

- ☐ Variety/Limit sweets
☐ Adequate Iron in females
☐ See Dentist
☐ Weight management
☐ Weight training/Changes
☐ Adequate sleep/Exercise

Health

- ☐ See Dentist
☐ Stress/Nervousness/Sadness
☐ Alcohol/ Drugs/ Tobacco
☐ How to say no/Abstinence
☐ Sexual feelings normal
☐ Body changes

Social/Behavior

- ☐ Family time
☐ Peer pressure/Refusal
☐ School activities
☐ Religious/Cultural/Volunteer activities

Physical Exam ✓=WNL, X=ABN (Describe abnormal findings)

Ht _____ in _____ %tile
 Wt _____ lbs _____ oz _____ %tile
 (See chart on separate page)

Patient Unclothed ☐ Yes ☐ No

☐ General Appearance _____

☐ Head _____

☐ Eyes _____

☐ Ears _____

☐ Nose _____

☐ Oropharynx _____

☐ Gums/Palate _____

☐ Neck _____

☐ Lungs _____

☐ Heart _____

☐ Abdomen _____

☐ Genitalia _____

☐ Extremities/Hips _____

☐ Spine _____

☐ Neurological _____

☐ Skin/Nodes _____

☐ Other _____

- ☐ Additional documentation on back
☐ Additional documentation on separate page

Screening ✓=WNL, X=ABN

Developmental/Behavioral Screen

- ☐ WNL (See separate page)
☐ ABN

Vision

- ☐ Parental observation/concerns
☐ Visual acuity
 ____ R ____ L ____ Both

Hearing

- ☐ Parental observations/concerns
☐ Screening audiometry, if not done previously

Vision

- ☐ Patient concerns
☐ Visual acuity
 ____ R ____ L ____ Both

Hearing

- ☐ Patient concerns
☐ Screening audiometry, if not done previously

Impression

- ☐ Well adolescent
☐ Normal growth
☐ Tanner Stage _____
☐ Normal development
☐ Low risk for tuberculosis
☐ Low risk for hyperlipidemia
☐ Other _____

Plan

- ☐ History updated
☐ Problem list, allergies, medication list updated
☐ Immunizations
 ☐ Up to date ☐ HBV ☐ Td
 ☐ MMR ☐ Varicella
☐ Other _____
☐ Hct or Hgb _____
☐ UA
☐ IPPD
☐ School Forms completed
☐ Urinalysis
☐ RTC for well check
☐ Referrals
 ☐ Transportation
 ☐ Dental
☐ Other referrals _____

Sign _____

14-20 Year Preventive Visit Form

DATE _____ NAME _____ DOB _____

Allergies: _____

Meds: _____

History

Nutrition

- ☐ Food (serv/day)
 ____ Meat/Egg
 ____ Veg/Fruit
 ____ Bread/Cereal
 ____ Milk/Dairy
 ☐ other _____
☐ City water ☐ Well water ☐ Bottled water

Urine Output

- ☐ Normal ☐ Decreased

Stools

- ☐ Normal ☐ Diarrhea ____/day
☐ Hard ____/day

Sleep

- ☐ Normal (8-12 hours)
☐ Abnormal

Menstrual

- ☐ Premenarchal
☐ Normal
☐ Abnormal

New Symptoms/Problems/Complaints

Anticipatory Guidance Health Education (✓ if discussed)

Safety

- ☐ Seatbelts/ Speed limits
☐ Self protection
☐ Sun screen/ Tanning salons
☐ Job safety
☐ Alcohol/ Drugs/ Weapons
☐ Athletic conditioning/ Fluids

Nutrition

- ☐ Food choices
☐ Weight management
☐ Three meals a day/ Nutritious snacks

Health

- ☐ Limit TV
☐ Birth control/STDs/ Safer sex
☐ How to say no/ Abstinence
☐ See Dentist
☐ Stress/ Nervousness/ Sadness
☐ Sexual feelings normal
☐ Alcohol/ Drugs/ Tobacco
☐ Gay/ Lesbian issues

Social/Behavior

- ☐ Trust feelings/ Listen to friends/ Adults
☐ Handle anger/ Conflict resolution
☐ Frustrations/ Dropping out
☐ Future plans/ College/ Career
☐ Respect others, parents' limits/ Consequences
☐ New skills/ Talents
☐ Health care consumer

Physical Exam ✓=WNL, X=ABN (Describe abnormal findings)

Ht _____ in _____ %tile
 Wt _____ lbs _____ oz _____ %tile
 (See chart on separate page)

Patient Unclothed ☐ Yes ☐ No

☐ General Appearance _____

☐ Head _____

☐ Eyes _____

☐ Ears _____

☐ Nose _____

☐ Oropharynx _____

☐ Gums/Palate _____

☐ Neck _____

☐ Lungs _____

☐ Heart _____

☐ Abdomen _____

☐ Genitalia _____

☐ Extremities/Hips _____

☐ Spine _____

☐ Neurological _____

☐ Skin/Nodes _____

☐ Other _____

Screening ✓=WNL, X=ABN

Developmental/Behavioral Screen

- ☐ Sexual development and behaviors
☐ (abstinence, STD prevention, BC)
☐ Tobacco/Alcohol/Substance/Anabolic steroid use/avoidance
☐ Body image and dieting patterns
☐ Emotional, physical and sexual abuse
☐ Emotional (Depression, Anxiety)
☐ School/Work problems
☐ Peer relationships
☐ Family relationships

Vision

- ☐ Patient concerns
☐ Visual acuity
 _____ R _____ L _____ Both

Hearing

- ☐ Patient concerns
☐ Screening audiometry, if not done previously

Impression

- ☐ Well adolescent
☐ Normal growth
☐ Tanner Stage _____
☐ Normal development
☐ Low risk for tuberculosis
☐ Low risk for hyperlipidemia
☐ Other _____

Plan

- ☐ History updated
☐ Problem list, allergies, medication list updated
☐ Immunizations
 ☐ Up to date ☐ HBV ☐ Td
 ☐ MMR ☐ Varicella
☐ Other _____
☐ Hct or Hgb _____
☐ UA
☐ IPPD
☐ School Forms completed
☐ Urinalysis
☐ RTC for well check
☐ Referrals
 ☐ Transportation
 ☐ Dental
 ☐ Other referrals _____
☐ Other _____

- ☐ Additional documentation on back
☐ Additional documentation on separate page

Sign _____

Recommended Childhood Immunization Schedule United States, January - December 2001*

Vaccines are listed under routinely recommended ages. **Bars** indicate range of recommended ages for immunization. Any dose not given at the recommended age should be given as a "catch-up" immunization at any subsequent visit when indicated and feasible. **Ovals** indicate vaccines to be given if previously recommended doses were missed or given earlier than the recommended minimum age.

Age Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	24 mos	4-6 yrs	11-12 yrs	14-18 yrs
Hepatitis B	Hep B #1											
		Hep B #2			Hep B #3						Hep B	
Diphtheria, Tetanus, Pertussis		DTaP	DTaP	DTaP			DTaP			DTaP	Td	
H influenza Type b		Hib	Hib	Hib		Hib						
Inactivated Polio		IPV	IPV		IPV					IPV		
Pneumococcal Conjugate		PCV	PCV	PCV		PCV						
Measles, Mumps Rubella						MMR				MMR	MMR	
Varicella						Var					Var	
Hepatitis A									Hep A - in selected areas			

* Approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

1. This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines as of 11/1/00, for children through 18 years of age. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and its other components are not contraindicated. Providers should consult the manufacturer's package inserts for detailed recommendations.
2. Infants born to HBsAg-negative mothers should receive the 1st dose of hepatitis B (Hep B) vaccine by age 2 months. The 2nd dose should be at least one month after the 1st dose. The 3rd dose should be administered at least 4 months after the 1st dose and at least 2 months after the 2nd dose, but not before 6 months of age for infants.
Infants born to HbsAg-positive mothers should receive hepatitis B vaccine and 0.5 mL hepatitis B immune globulin (HBIG) within 12 hours of birth at separate sites. The 2nd dose is recommended at 1-2 months of age and the 3rd dose at 6 months.
Infants born to mothers whose HbsAg status is unknown should receive hepatitis B vaccine within 12 hours of birth. Maternal blood should be drawn at the time of delivery to determine the mother's HbsAg status; if the HbsAg test is positive, the infant should receive HBIG as soon as possible (no later than 1 week of age).
All children and adolescents who have not been immunized against hepatitis B should begin the series during any visit. Special efforts should be made to immunize children who were born in or whose parents were born in areas of the world with moderate high endemicity of hepatitis B virus infection.
3. The 4th dose of DtaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) may be administered as early as 12 months of age, provided 6 months have elapsed since the 3rd dose and the child is unlikely to return at 15-18 months. TD (tetanus and diphtheria toxoids) is recommended at 11-12 years of age if at least 5 years have elapsed since the last dose of DTP, DtaP or DT. Subsequent routine TD boosters are recommended every 10 years.
4. Three *Haemophilus influenzae* type b (Hib) conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB or Comvax [Merck]) is administered at 2 and 4 months of age, a dose at 6 months is not required. Because clinical studies in infants have demonstrated that using some combination products may induce a lower immune response to the Hib vaccine component, DtaP/Hib combination products should not be used for primary immunization in infants at 2, 4 or 6 months of age, unless FDA-approved for these ages.
5. An all-IPV schedule is recommended for routine childhood polio vaccination in the United States. All children should receive four doses of IPV at 2 months, 4 months, 6-18 months, and 4-6 years of age. Oral polio vaccine (OPV) should be used only in selected circumstances. (See MMWR May 19, 2000/49 (RR-5); 1-22).
6. The heptavalent conjugate pneumococcal vaccine (PVC) is recommended for all children 2-23 months of age. It also is recommended for certain children 24-59 months of age. (See MMWR Oct. 6, 2000/49(RR-9); 1-35).
7. The 2nd dose of measles, mumps, and rubella (MMR) vaccine is recommended routinely at 4-6 years of age but may be administered during any visit, provided at least 4 weeks have elapsed since receipt of the 1st dose and that both doses are administered beginning at or after 12 months of age. Those who have not previously received the 2nd dose should complete the schedule by the 11-12 year visit.
8. Varicella (Var) vaccine is recommended at any visit on or after the first birthday for susceptible children, i.e. those who lack a reliable history of chickenpox (as judged by a health care provider) and who have not been immunized. Susceptible persons 13 years of age or older should receive 2 doses, given at least 4 weeks apart.
9. Hepatitis A (Hep A) is shaded to indicate its recommended use in selected states and/or regions, and for certain high risk groups; consult your local public health authority. (See MMWR Oct. 1, 1999/48(RR-12), 1-37).

For additional information about the vaccines listed above, please visit the National Immunization Program Home Page at <http://www.cdc.gov/nip/> or call the National Immunization Hotline at 1-800-232-2522 (English) or 1-800-232-0233 (Spanish).

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Department of Adolescent Health, American Medical Association, 515 North State Street,
Chicago, IL 60610 <http://www.ama-assn.org/ado/hlth/adolhlth.htm>
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CDC, 1600 Clifton Road, Atlanta, GA 30333 <http://www.cdc.gov>
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<http://www.hcfa.gov/medicaid/ch%2Dguide.htm>
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<http://www.psychcorp.com>
<http://edge.net/-evpress>
Behavioral/Emotional: <http://www.parinc.com>
<http://www.dbpeds.org/handouts>
15. Brigance Screens: Brigance A.N. Billerica, MA: Curriculum Associates, Inc. (1985) 153
Rangeway Road, PO Box 2001, North Billerica, MA 01862-090 (1-800-225-0248)
<http://www.curriculumassociates.com>
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EPSDT Billing Guidelines

Coding Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services using appropriate preventive CPT™ codes will ensure providers receive the highest level of benefits possible.

Preventive codes:

New Patient

99381	under one (1) year
99382	1-4 years
99383	5-11 years
99384	12-17 years
99385	18-39 years

Established Patient

99391	under one (1) year
99392	1-4 years
99393	5-11 years
99394	12-17 years
99395	18-39 years

Newborn Care (History and Examination)

99431

Normal Newborn Care

99432

Providers are allowed to bill these services under Evaluation and Management (E&M) codes **with** diagnosis codes V20-V20.2, V70.0, V70.3-V70.9, but reimbursement may be at a lesser rate than if billed using preventive codes.

Evaluation & Management codes:

New Patient

99201
99202
99203
99204
99205

Established Patient

99211
99212
99213
99214
99215

Note: Providers should bill a preventive code *plus* an Evaluation and Management code *with* Modifier 25 when the visit includes both preventive care and services for an exhibited illness or condition.

CPT™ is a trademark of the American Medical Association

Sample copies of preventive services filed on a HCFA-1500 claim form follows:

Sample HCFA-1500 Claim Form

PLEASE
DO NOT
STAPLE
IN THIS
AREA

APPROVED OMB 0938-0008

HEALTH INSURANCE CLAIM FORM																																																																																																																																																
<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> PICA </div> <div> <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) </div> <div> <input type="checkbox"/> PICA </div> </div>																																																																																																																																																
1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) A123456789																																																																																																																																											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane					3. PATIENT'S BIRTH DATE MM DD YY 1 1 90 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																																																																									
5. PATIENT'S ADDRESS (No., Street) 123 Main Street					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input checked="" type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)																																																																																																																																									
CITY Anytown			STATE TN		8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE																																																																																																																																							
ZIP CODE 12345			TELEPHONE (Include Area Code) ()			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:																																																																																																																																								
11. INSURED'S POLICY GROUP OR FECA NUMBER					12. INSURED'S DATE OF BIRTH SEX MM DD YY M F																																																																																																																																											
13. EMPLOYER'S NAME OR SCHOOL NAME					14. INSURANCE PLAN NAME OR PROGRAM NAME																																																																																																																																											
15. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 1a & d.					16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below)																																																																																																																																											
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17. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits, either to myself or to the party who accepts assignment below)																																																																																																																																																
SIGNED _____ DATE _____																																																																																																																																																
18. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 8 1 99					19. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY																																																																																																																																											
20. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					21. I.D. NUMBER OF REFERRING PHYSICIAN																																																																																																																																											
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Sample HCFA-1500 Claim Form

APPROVED OMB-0938-0008

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(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE &BB)

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FORM HCFA 1500 (12-90)
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Mental Health Screening Component of EPSDT

An effective developmental/behavioral screening tool should be easy to use during the course of an EPSDT screening visit and have sensitivity, specificity, and reproducibility. The EPSDT Guidelines Committee of TennCareSM included behavioral health and primary care practitioners who researched this issue thoroughly. Their recommendations of screening instruments mirror other states and institutions and are discussed in the EPSDT Guidelines (see previous section). The Pediatric Symptom Checklist (PSC) and Parents Evaluation of Developmental Status (PEDS) have valid studies attesting to their use as screening tools, are easy to learn, and are widely available. The screening tests proposed rely heavily on observations of the child's caregivers. In issues of state custody, the person bringing the child to the initial EPSDT exam may not have had sufficient contact with the child to give an adequate history. Regardless of the type or complexity of test used, the provider will be hampered by lack of history. Therefore, any initial behavioral screen must take this issue into account and the practitioner may need to rescreen the child after an appropriate length of stay in a foster care setting. Referral to a behavioral health provider should be made whenever the child's screening tests indicate a problem the BPN practitioner does not feel comfortable treating or whenever the practitioner, DCS worker, or foster parent feel it is indicated.

Developmental & Behavioral Screening

Developmental and Behavioral Screening

Frances Page Glascoe, Ph.D. Nashville, TN

Henry Shapiro, M.D., St. Petersburg, FL

Overview

About 16% of children have disabilities such as speech-language impairments, mental retardation, learning disabilities, and emotional/behavioral disturbance. Although such children are twice as likely to seek health care than children without disabilities, only half are detected prior to school entrance. The reasons are understandable: Most disabilities are subtle and children who have them often appear to be developing normally especially at younger ages.

Nevertheless, underdetection is unfortunate because it eliminates the possibilities of early intervention. Children who participate in early intervention programs prior to kindergarten are more likely to graduate from high school, hold jobs, live independently and to avoid teen pregnancy or delinquency. These positive outcomes save society between \$30,000 to \$100,000 per child.

In order to improve pediatricians' ability to detect children with developmental and emotional/behavioral problems, the American Academy of Pediatrics Committee on Children with Disabilities recommends the use of standardized screening tests at each well visit. However, most pediatricians find the more popular measures too lengthy to give routinely. Many such measures also lack accuracy and fail to sensitively identify children with difficulties.

Fortunately, several recently published tools are far more suitable for busy pediatric offices because they are both quick and accurate. Several take only a few minutes to give and improve on existing detection rates by 25% to 30%.

Who Should Be Screened?

Contrary to some beliefs, low-income parents and those with limited education can complete parent-report screens. The results can be as useful as screens completed by parents with higher levels of education. Asking parents (in their primary language) if they would prefer to have some one go through the measure with them should circumvent literacy barriers.

On a similar note, screening tests work best in populations with moderate levels of risk for disabilities, such as low income, limited education, families with lots of other risk factors such as mental health problems, single parents, many children in the home, and unemployment.

It is possible to identify groups with very high or very low levels of risk by noting the presence or absence of parental concerns. It is not a good idea to administer additional secondary screens to these high and low risk groups. Sensitivity or specificity will fall out of the acceptable ranges of 70% to 80%. If a clinician is able to discover whether a parent is concerned or not, referral or non-referral decisions can be made immediately in approximately 80 per cent of the cases, with additional screening reserved for the remaining 20 per cent.

Nevertheless, eliciting parents' concerns is tricky in itself. Parents' do not respond well to some terms (e.g., do you have any worries about your child's development?) For this reason, one tool, described below, uses carefully standardized and validated questions.

Pitfalls of Screening

There are three major pitfalls of screening:

1. ***Waiting until a problem is observable.*** Clinicians often use screening tools only after they've noticed a problem. If the problem is obvious, referring may be the best response. Screening such children may compound rather than reduce the error in both clinical judgment and screening tools.
2. ***Ignoring screening results.*** Many times, screening test results are not taken seriously and children who fail are not referred but rather viewed with a wait and see attitude. Good screens are right 70 to 80 per cent of the time. There is no evidence to support "temporizing" in such a situation, and harm could result from delayed diagnosis and intervention.
3. ***Relying on informal methods.*** Informal tools such as checklists often contain items sure to miss most kids with problems (such as the checklists on many encounter forms). These are often based on instruments such as the original Denver Developmental Screening Test, which missed up to 50 per cent of mental retardation and 70 per cent of language impairment.

Checklists provide no validated criteria for referrals, and have unknown reliability. Validated and standardized tools carry the burden of proof that informal measures lack. We would never select tools for blood lead or other medical screens with questionable or unknown levels of accuracy. Why do we do this with development?

Summary

Developmental and Behavioral screening is a well-developed technology. These instruments are superior to informal methods that are now being used in many offices. Many instruments are also available in Spanish, and some in other languages. We have listed a number of valid and reliable screening instruments that are suitable for office use.

References

Developmental and Behavioral News, *Frances Page Glascoe, Ph.D. and Henry Shapiro, M.D.*

<http://www.dbpeds.org>, Pediatric Development and Behavior Homepage, sponsored by *Maternal and Child Health Bureau* and *American Academy of Pediatrics*

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Updated December 03, 1999

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Psychosocial Problems, Screening, and the Pediatric Symptom Checklist

by Michael Jellinek, M.D. and J. Michael Murphy, Ed.D. Boston, MA

Introduction

Pediatricians have long been an important first resource for parents who are worried about their children's behavioral problems. Primary care providers in managed care settings assume an even greater "gatekeeping" responsibility to identify, manage and refer children with emotional and/or behavioral disorders. Yet, recent studies estimate that only about 50% of these children are identified by their primary care physicians and that once identified, only a fraction of these children receive appropriate mental health treatment.

12-25% of all American school-age children and 13% of preschoolers have an emotional and/or behavioral disorder. The rates of psychosocial impairment are higher in risk groups such as low income and/or single parent households. A number of studies have documented an increasing prevalence of behavioral and emotional problems in the U.S. and other countries in children and adults. Despite the growing burden of psychosocial morbidity, pediatricians often may not receive adequate training concerning psychosocial problems, are hesitant to attach potentially deleterious labels to children, do not have time during office visits to address psychosocial needs, and may have limited access to mental health referral networks.

There has been increasing attention on psychosocial problems. Organized medical education groups have increased the behavioral training requirements. Publications such as Bright Futures, and the Diagnostic and Statistical Manual for Primary Care may help to increase awareness of psychosocial morbidity over the long-term, but as of now primary care pediatricians still struggle to provide psychosocial services.

Managed care and the increasing focus on productivity and profitability are creating additional pressure for pediatric clinicians to limit attention on psychosocial problems. One way to counter balance these pressures is to use a parent-completed screening questionnaire as part of routine primary care visits which would facilitate recognition of psychosocial problems. The Pediatric Symptom Checklist (PSC) was developed to serve this purpose.

What is the PSC?

The PSC is a one-page questionnaire listing a broad range of children's emotional and behavioral concerns that reflects parents' impressions of their children's psychosocial functioning. In a number of validity studies, PSC case classifications agreed with case classifications on the Child Behavior Checklist (CBCL), Clinicians' Global Assessment Scale (CGAS) ratings of impairment, and the presence of a psychiatric disorder in a variety of pediatric and subspecialty settings representing diverse socioeconomic backgrounds.

Compared with the CGAS, the PSC has 79% agreement for middle income children and 92% agreement for lower income children. Sensitivity is 95% for middle income and 88% for lower income and specificity 68% for middle income and 100% for lower income children.

Studies using the PSC have found prevalence rates of psychosocial impairment in middle class or general settings of about 12%, quite comparable to national estimates of psychosocial problems. Some investigators have recommended that the PSC should be considered "basic office equipment" in pediatrics and others have argued that the PSC should become a mandated part of all well-child visits in managed care settings or large programs like Medicaid EPSDT.

Several states (e.g., Arizona, Massachusetts) now recommend the PSC or other brief questionnaires for psychosocial screening during EPSDT, and a number of HMO's (Kaiser of Northern California, Neighborhood Health Plan of Massachusetts) are piloting the use of the PSC as a routine part of well-child visits. The PSC is also being used as a part of annual screenings in a variety of non-health care settings like Ventura County, California Head Start.

Use in Practice

The PSC is designed to be administered in the waiting room and scored by a receptionist or clinical aide. A positive score reflects a high likelihood that a child is having significant psychosocial dysfunction. Although certain responses may suggest a diagnosis, the PSC is a screening tool and not diagnostic. If positive, the clinician should pursue a brief interview reviewing the child's major areas of functioning (school, family, activities, friends and mood). If this brief interview supports the PSC findings, the clinician then decides whether a follow-up appointment, further evaluation or referral is indicated.

Administration and Scoring

The Pediatric Symptom Checklist obtains parents' reports of children's behavioral/emotional problems on 35 items that describe specific behaviors and emotions. Parents rate their child for how true each item is using the following scale: 0= not true (as far as you know); 1=somewhat or sometimes true; 2=very true or often true. For school aged children 6-16 years, a total score of 28 or higher is taken as an indication of significant and psychosocial impairment. For children ages 2-5, the scores on items 6, 7, 14 and 15 are ignored and a total score based on the 31 remaining items is completed.

The cutoff score for younger children is 24 or greater. Although parents have been shown to be the most reliable reporters of their children's psychosocial and behavioral problems, some mood disorders especially in adolescents are more reliably identified by the patients themselves. When problems like these are suspected interviewing the child or adolescent, the youth self-report of the PSC, or a specific disorder screen like the Children's Depression Inventory may be more valid.

Future Directions

Parental acceptance of the PSC has been reconfirmed by our recent research on a national sample. Poverty, single parent family, family history of mental illness, among other factors, elevates the percentage of children scoring positive on the PSC. We are now studying whether recognizing problems using the PSC will reduce costs by decreasing the utilization of primary health care.

Editor's Note:

The PSC has its own web site: <http://healthcare.partners.org/psc/>

The PSC and this article are available on the Pediatric Development and Behavior site, <http://www.dbpeds.org/handouts/>

Recommended Reading

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PARENTS' EVALUATION OF DEVELOPMENTAL STATUS

*A method for detecting and
addressing developmental and
behavioral problems in children*

BRIEF ADMINISTRATION AND SCORING GUIDE

In health care and educational settings, parents often raise concerns about their child's language, behavior or other areas of development. Deciding on the best response is often challenging:

- Do concerns reflect such potentially serious problems that diagnostic testing is needed?
- Do parents simply need advice, and if so, on what topics?
- Should a developmental or behavioral screening test be administered?
- Should a child be watched carefully over time to ensure prompt attention for any emerging problems?
- Are reassurance and routine monitoring sufficient?

In contrast, some parents do not readily share their concerns. Others share them at times when it is difficult for professionals to respond carefully (e.g., by raising "oh by the way" comments at the end of a pediatric visit) while some parents

need help carefully appraising how their child is developing compared to others. Under these circumstances, it is challenging for professionals, especially those in busy medical settings, to detect and address families' psychosocial needs. All this contributes to the finding that fewer than 30% of children with serious developmental and behavioral difficulties are identified before school entrance.

The subtle and emerging nature of children's problems also contributes to under-detection. For example, almost all children begin to talk at the usual time, but those with problems may have trouble learning new vocabulary or combining words. Nevertheless, failure to detect subtle difficulties means that children do not receive the benefits of early intervention. These benefits include greater likelihood of graduating from high school, living independently, holding a job, and delaying childbearing. Lack of early intervention contributes to the fact that 1 in 3 children has either disabilities or substantial school difficulties, 28% drop out of high school.

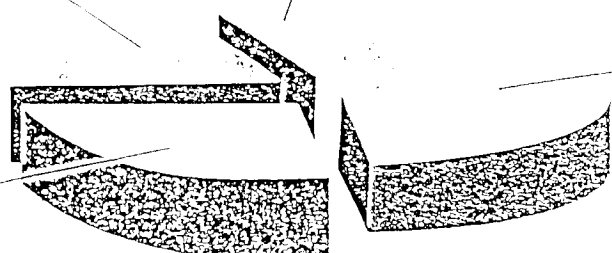
PEDS was designed to facilitate parent professional communication and to ensure that developmental and behavioral problems in children 0 to 8 years of age are detected and addressed. This is accomplished by carefully eliciting parents' concerns, determining children's level of risk for disabilities, and identifying the optimal professional response. Extensive PEDS research on children reveals that

26% have a moderate risk of disabilities and need screening, developmental promotion and vigilant observation

11% have a high risk of disabilities and need referrals for further evaluations

43% have a low risk of disabilities and need only routine monitoring

20% have a low risk of disabilities, but need mostly behavioral guidance



For children who rarely attend well-visits, PEDS can be used at sick- or return-visits. Early childhood professionals may wish to use PEDS annually or semi-annually as suggested by the National Association for Education of Young Children and other education organizations.

Child's Age	0-3 mos	4-5 mos	6-11 mos	12-17 mos	18-23 mos	24-35 mos	36-47 mos	48-59 mos	60-71 mos	72-83 mos	84-95 mos	96-107 mos	108-119 mos	120-131 mos	132-143 mos	144-155 mos	156-167 mos	168-179 mos	180-191 mos	192-203 mos	204-215 mos	216-227 mos	228-239 mos	240-251 mos	252-263 mos	264-275 mos	276-287 mos	288-299 mos	300-311 mos	312-323 mos	324-335 mos	336-347 mos	348-359 mos	360-371 mos	372-383 mos	384-395 mos	396-407 mos	408-419 mos	420-431 mos	432-443 mos	444-455 mos	456-467 mos	468-479 mos	480-491 mos	492-503 mos	504-515 mos	516-527 mos	528-539 mos	540-551 mos	552-563 mos	564-575 mos	576-587 mos	588-599 mos	600-611 mos	612-623 mos	624-635 mos	636-647 mos	648-659 mos	660-671 mos	672-683 mos	684-695 mos	696-707 mos	708-719 mos	720-731 mos	732-743 mos	744-755 mos	756-767 mos	768-779 mos	780-791 mos	792-803 mos	804-815 mos	816-827 mos	828-839 mos	840-851 mos	852-863 mos	864-875 mos	876-887 mos	888-899 mos	900-911 mos	912-923 mos	924-935 mos	936-947 mos	948-959 mos	960-971 mos	972-983 mos	984-995 mos	996-1007 mos	1008-1019 mos	1020-1031 mos	1032-1043 mos	1044-1055 mos	1056-1067 mos	1068-1079 mos	1080-1091 mos	1092-1103 mos	1104-1115 mos	1116-1127 mos	1128-1139 mos	1140-1151 mos	1152-1163 mos	1164-1175 mos	1176-1187 mos	1188-1199 mos	1200-1211 mos	1212-1223 mos	1224-1235 mos	1236-1247 mos	1248-1259 mos	1260-1271 mos	1272-1283 mos	1284-1295 mos	1296-1307 mos	1308-1319 mos	1320-1331 mos	1332-1343 mos	1344-1355 mos	1356-1367 mos	1368-1379 mos	1380-1391 mos	1392-1403 mos	1404-1415 mos	1416-1427 mos	1428-1439 mos	1440-1451 mos	1452-1463 mos	1464-1475 mos	1476-1487 mos	1488-1499 mos	1500-1511 mos	1512-1523 mos	1524-1535 mos	1536-1547 mos	1548-1559 mos	1560-1571 mos	1572-1583 mos	1584-1595 mos	1596-1607 mos	1608-1619 mos	1620-1631 mos	1632-1643 mos	1644-1655 mos	1656-1667 mos	1668-1679 mos	1680-1691 mos	1692-1703 mos	1704-1715 mos	1716-1727 mos	1728-1739 mos	1740-1751 mos	1752-1763 mos	1764-1775 mos	1776-1787 mos	1788-1799 mos	1800-1811 mos	1812-1823 mos	1824-1835 mos	1836-1847 mos	1848-1859 mos	1860-1871 mos	1872-1883 mos	1884-1895 mos	1896-1907 mos	1908-1919 mos	1920-1931 mos	1932-1943 mos	1944-1955 mos	1956-1967 mos	1968-1979 mos	1980-1991 mos	1992-2003 mos	2004-2015 mos	2016-2027 mos	2028-2039 mos	2040-2051 mos	2052-2063 mos	2064-2075 mos	2076-2087 mos	2088-2099 mos	2100-2111 mos	2112-2123 mos	2124-2135 mos	2136-2147 mos	2148-2159 mos	2160-2171 mos	2172-2183 mos	2184-2195 mos	2196-2207 mos	2208-2219 mos	2220-2231 mos	2232-2243 mos	2244-2255 mos	2256-2267 mos	2268-2279 mos	2280-2291 mos	2292-2303 mos	2304-2315 mos	2316-2327 mos	2328-2339 mos	2340-2351 mos	2352-2363 mos	2364-2375 mos	2376-2387 mos	2388-2399 mos	2400-2411 mos	2412-2423 mos	2424-2435 mos	2436-2447 mos	2448-2459 mos	2460-2471 mos	2472-2483 mos	2484-2495 mos	2496-2507 mos	2508-2519 mos	2520-2531 mos	2532-2543 mos	2544-2555 mos	2556-2567 mos	2568-2579 mos	2580-2591 mos	2592-2603 mos	2604-2615 mos	2616-2627 mos	2628-2639 mos	2640-2651 mos	2652-2663 mos	2664-2675 mos	2676-2687 mos	2688-2699 mos	2700-2711 mos	2712-2723 mos	2724-2735 mos	2736-2747 mos	2748-2759 mos	2760-2771 mos	2772-2783 mos	2784-2795 mos	2796-2807 mos	2808-2819 mos	2820-2831 mos	2832-2843 mos	2844-2855 mos	2856-2867 mos	2868-2879 mos	2880-2891 mos	2892-2903 mos	2904-2915 mos	2916-2927 mos	2928-2939 mos	2940-2951 mos	2952-2963 mos	2964-2975 mos	2976-2987 mos	2988-2999 mos	3000-3011 mos	3012-3023 mos	3024-3035 mos	3036-3047 mos	3048-3059 mos	3060-3071 mos	3072-3083 mos	3084-3095 mos	3096-3107 mos	3108-3119 mos	3120-3131 mos	3132-3143 mos	3144-3155 mos	3156-3167 mos	31
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Categorizing parents' concerns

TYPE OF CONCERN	TYPICAL RESPONSES	If present, mark the box in the age-appropriate column on the PEDS Score Form for:
Global/Cognitive	<i>Seems behind, can't do what other kids can; slow and behind other kids; immature; learns slowly; late to learn to do things; learns but takes a long time, problems with learning everything</i>	Item 1
Expressive Language and Articulation	<i>Not talking like he should, uses short sentences; can't always say what she means, doesn't always make sense; can't talk plain. Nobody understands what he is saying but me</i>	Item 2
Receptive Language	<i>Doesn't understand what you say, doesn't listen well</i>	Item 3
Fine-Motor	<i>Can't stay in the lines when coloring, can't write name, can't draw shapes, can't hold a pencil right, can't get food to mouth with a spoon yet and so is a messy eater</i>	Item 4
Gross Motor	<i>Clumsy, walks funny, can't ride a bike yet, falls a lot, limps, poor balance, hates soccer</i>	Item 5
Behavior	<i>Stubborn; over-active, short attention span, spoiled; aggravating, throws fits, only does what she wants</i>	Item 6
Social-emotional	<i>Wants to be left alone, mood swings, clingy, whiny, bothered by changes; angry, disinterested in usual things, easily led, acts mean, easily frustrated, bossy; shy, class clown, is angry, mean, hates me</i>	Item 7
Self-help	<i>Won't do things for herself, won't tell me when he's wet; not toilet trained yet, still wants a bottle, can't get dressed by herself</i>	Item 8
School	<i>Can't write his name (scored also with fine motor), doesn't know colors or numbers, just not learning to read, can't remember letter sounds, knows spelling words one day but not the next</i>	Item 9
Other	<i>Ear infections, asthma, small for age, sick a lot, I don't think he hears well, She gets up too close to the TV and I worry about her sight</i>	Item 10
No concerns	<i>Typical child, development is normal, he's coming along just fine, she's advanced</i>	If no concerns are raised, leave boxes empty and proceed to step 4

Step 3: Mark boxes on the Score Form for each concern raised in Question 1.

Read parents' responses to Question 1 on the PEDS Response Form. Then view the table on the previous page to decide which box(es) to mark on the PEDS Score Form.

If parents make statements such as "I was worried but now I think she's doing better," mark this as a concern!

in the developmental area mentioned.

Similarly, when parents report that they are only "a little" concerned, this too should be marked as a concern.

Child's Name Jane Smith Parent's Name Joan Smith
Child's Birthday 2/2/75 Child's Age 3 yrs Today's
Please list any concerns about your child's learning, development and behavior.
Jane is spoiled. She still wants a bottle. She walks funny too.

spoiled

still wants bottle

walks funny

5. Gross Motor

6. Behavior

7. Social-emotional

8. Self-help

9. School

Step 4: Mark boxes on the Score Form for each concern listed in Questions 2–10.

For each item marked "Yes" or "A little" on the PEDS Response Form, put a check on the PEDS Score Form in the corresponding box.

If parents do not write anything on the PEDS Response Form except to circle an occasional "Yes" or "A little" on Questions 2-10, illiteracy may be a problem. Double check responses by re-administering the PEDS Response Form by interview.

2. Do you have any concerns about how your child talks and makes speech?
 Circle one: No Yes A little COMMENTS:

3. Do you have any concerns about how your child understands what you
(circle one) No

2. Expressive Language and Articulation ☐ ☐

3. Receptive Language ☐ ☐

4. Fine-Motor ☐ ☐

4. Do you have any concerns about how your child uses his or her hair?
 Circle one: ☒ No ☐ Yes A little COMMENTS

Step 5: Summarize Concerns on the PEDS Score Form.

The small shaded boxes on the PEDS Score Form show the Significant Concerns (those most predictive of disabilities). Count the number of checks in the small shaded boxes in the column above and write the total in the large shaded box near the bottom of the PEDS Score Form _____

The small non-shaded boxes on the PEDS Score Form show the Nonsignificant Concerns (those not predictive of disabilities). Count the checks in the small non-shaded boxes and write the total in the large non-shaded box at the very bottom of the PEDS Score Form _____

Child's Age	1-2 Years	2-3 Years	3-4 Years	4-5 Years	5-6 Years	6-7 Years	7-8 Years	8-9 Years	9-10 Years
1. Global Cognitive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Expressive Language and Articulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Receptive Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Fine Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Gross Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Social-emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Self-help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Count the number of checks in the small shaded boxes and write the number in the large shaded box below.

0 1 2 3 4 5 6 7 8 9

Public number shown in the large shaded box is 2.

Follow Path A on PLOS Interpretation Form. If the number shown in the large shaded box is 2, follow Path B. If the number shown in the large shaded box is 1, 3, 4, 5, 6, 7, 8, or 9, follow Path C.

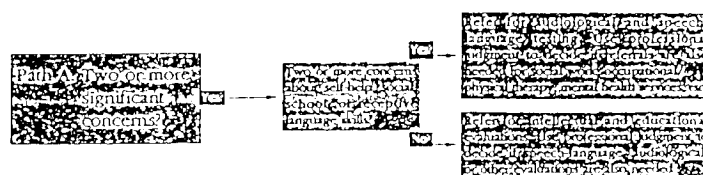
7

DIRECTIONS FOR INTERPRETATION

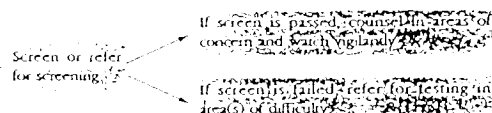
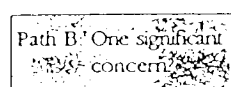
Step 6: Determine the Appropriate Path to follow on the PEDS Interpretation Form.

Follow Path A if the number listed in the large shaded box of the PEDS Score Form is 2 or more (multiple of the significantly predictive concerns). These children have a high risk of problems (20 times that of children whose parents do not have concerns)—70% have disabilities or substantial delays. Screening this group results in under-referrals, thus referrals for diagnostic testing are needed. The PEDS Interpretation Form suggests the kinds of referrals that should be most helpful. Those children not found to have disabilities

are still likely to have below-average performance. Private speech therapy, early stimulation programs (e.g., Head Start or day care) and other services should be marshaled



Follow Path B if the number listed in the large shaded box is exactly 1 (a single significantly predictive concern). These children have a moderate risk of serious difficulties (8 times that of children whose parents do not have concerns)—30% have

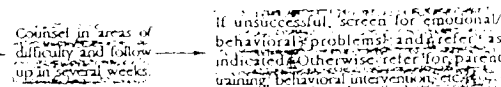
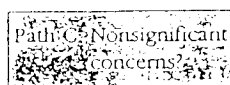


disabilities. Additional screening is needed to determine which children need referrals and which do not. Those who

fail screening should be referred for further testing. Those who pass screening need developmental promotion, patient education and vigilant follow-up, since they may have emerging disabilities or below-average intelligence, language, or school skills. Where facilities, time, or tools are limited, children can be referred for screening through the public schools or early intervention programs (see www.nectas.unc.edu for information about local programs). Information

about accurate developmental screening measures is included near the end of this guide.

Follow Path C if the number in the large unshaded box is 1 or more (nonsignificantly predictive concerns) and the number in the large shaded box is 0 (no significantly predictive concerns). These children have only a low risk of disabilities (1.3 times that of children whose parents have no concerns). Only 7% of these children have developmental disabilities, although about 25% have emotional and behavioral difficulties. The best response is to counsel parents about their concerns (most are about children's behavior) and to monitor their progress closely. If such counseling is unsuccessful (it is advisable to check on progress after several weeks), professionals should screen for behavioral/emotional



problems and refer children who fail for mental health services (e.g., family counseling, child psychiatry or psychology, social work, mental health centers, etc.). When children pass a behavioral/emotional screen, somewhat less intensive services can be recommended, such as parent-training or behavioral intervention programs. Information about accurate

emotional/behavioral screening tools is included near the end of this guide.

SOURCES FOR INFORMATION HANDOUTS

For use with Paths A through D

Instructions for Patient Education

Barton Schmitt

W.B. Saunders Co.

Independence Square West

Philadelphia, PA 19106 (800-545-2522)

Discipline Without Shouting or Spanking

Wyckoff & Unell

Simon & Schuster

1230 Avenue of the Americas

New York, NY 10020 (800-223-2336)

Downloadable handouts from the American Academy of Child and Adolescent Psychiatry: These include 51 fact sheets written in Spanish, French and English on such topics as divorce, disaster recovery, how to choose a psychiatrist, etc. (www.aacap.org/web/aacap/factsFam/)

Downloadable handouts from the Ambulatory Pediatric Association for developmental promotion and other non-medical issues: (www.ambpeds.org/ParentHandouts/APAHandoutsTOC.html). Also included in the PEDS manual, *Collaborating With Parents*.

ACCURATE SECOND-STAGE SCREENING TESTS For use with Paths B and D

DEVELOPMENTAL SCREENING TESTS

Bayley Scales Infant Development Questionnaire

Bayley Scales II (1993)
Paul H. Brookes Publishers
PO Box 10624
Baltimore, MD 21285 (800-638-3775)
(\$150) (ages 0-48 months)
Uses parent report and takes 5-10 minutes.

Gold Development Inventories

Frederick J. (1992)
Behavior Science Systems
Box 580274
Minneapolis, MN 55458 (612-929-6220)
(\$41.00) (ages 0-6)

Uses parent report and takes about 10 minutes.

Bayley Infant Neurodevelopmental Screener

Wyward GP
Psychological Corporation
555 Academic Court
San Antonio, TX 78204 (800-228-0752)

(\$195.00 with 25 forms) (ages 3-24 months)
Uses a combination of parent report and direct elicitation. Takes about 15 minutes.

Brigance screens

Brigance A
Curriculum Associates, Inc.
Five Squire Road
Natick, MA 01862 (800-225-0248)
(\$248.00 with 100 forms) (ages 21 months-2nd grade)
All skills are directly elicited from children.
Takes about 10 minutes.

Battelle Developmental Inventory Screening Test

Newborg et al. (1984)
Riverside Publishing Company
8420 Bryn Mawr Avenue
Chicago, IL 60631 (800-767-8378)
(\$99.00+\$270 if materials kit is purchased, but test stimuli can be obtained for about \$50 by shopping at discount department stores) (ages 1-8)
This test uses a combination of parent report and direct elicitation. Takes 20-35 minutes.

BEHAVIORAL, EMOTIONAL, and PSYCHOSOCIAL SCREENING TESTS

Eyberg Child Behavior Inventory

Eyberg S. et al.
The measure is published with an article in the *Journal of Clinical Child Psychology* 1980, 9:22-29 (ages 2-11).
Parent report. Takes about 5 minutes.

Pediatric Symptom Checklist

Jellinek MS, Murphy JM, Robinson J, et al.
The measure is reprinted in the complete PEDS manual and in the *Journal of Pediatrics* (1988, 112:201-209). Pediatric Symptom Checklist screening school-age children for psychosocial dysfunction. (ages 1-16)
Parent report. Takes about 5 minutes.

Family Psychosocial Screening

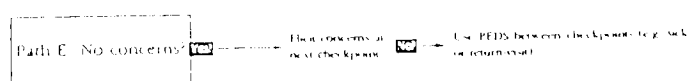
Kemper J S, Kelleher K J
The measures are reprinted in the complete PEDS manual and in *Ambulatory Child Health* (1996, 14) 325-339. Family psychosocial screening: instruments and techniques.
Screens families for depression, substance abuse, history of abuse as a child and other risk factors for developmental/behavioral problems in children.

Follow Path D if there are zeros in both large boxes (no concerns of either type) but parents have difficulty communicating due to language barriers, lack of familiarity with the child (e.g., another family member provides most of the



Follow Path E if there are zeros in both large boxes (no concerns) and parents are able to communicate well. These children are at low risk and only 5% have delays or disabilities. This group requires only reassurance and routine monitoring by re-administering PEDS at the next expected check point (e.g., annual re-screening, well visit, or sick/return visit when families do not keep well-visit appointments).

care), parental mental health problems, etc. These children (about 3 out of 100) have a moderate risk of disabilities (4 times that of children whose parents have no concerns and no communication difficulties). Almost 20% have disabilities while 35% have delays. Additional screening is needed, preferably through the schools or early intervention/stimulation programs, since interpreters or social work services may be required for obtaining quality information from these parents. Those who pass screening remain at risk for difficulties. Developmental promotion and vigilant follow-up are needed for this group.



If parents have no concerns or nonsignificant concerns, but clinical judgment suggests the presence of a problem, follow Path A or B.

Step 7: Complete the Interpretation Form.

On the far right of the PEDS Interpretation Form is space to list specific decisions: referrals, additional screening test results, counseling topics, plans for future encounters, etc. This form can be used across multiple encounters to follow children over time.

Because PEDS questions are similar to those asked by many professionals, it may be tempting to reword or reinterpret PEDS in a manner different from that presented here. However, research shows that altering questions leads to substantial under identification of children with problems.

Specific Decisions

0-3 mos	
4-5 mos	
6-11 mos	
12-15 mos	
16-24 mos	
25-36 mos	
37-48 mos	
49-60 mos	
61-72 mos	
73-84 mos	
85-96 mos	
97-108 mos	
109-120 mos	
121-132 mos	
133-144 mos	
145-156 mos	
157-168 mos	
169-180 mos	
181-192 mos	
193-204 mos	
205-216 mos	
217-228 mos	
229-240 mos	
241-252 mos	
253-264 mos	
265-276 mos	
277-288 mos	
289-300 mos	
301-312 mos	
313-324 mos	
325-336 mos	
337-348 mos	
349-360 mos	
361-372 mos	
373-384 mos	
385-396 mos	
397-408 mos	
409-420 mos	
421-432 mos	
433-444 mos	
445-456 mos	
457-468 mos	
469-480 mos	
481-492 mos	
493-504 mos	
505-516 mos	
517-528 mos	
529-540 mos	
541-552 mos	
553-564 mos	
565-576 mos	
577-588 mos	
589-600 mos	
601-612 mos	
613-624 mos	
625-636 mos	
637-648 mos	
649-660 mos	
661-672 mos	
673-684 mos	
685-696 mos	
697-708 mos	
709-720 mos	
721-732 mos	
733-744 mos	
745-756 mos	
757-768 mos	
769-780 mos	
781-792 mos	
793-804 mos	
805-816 mos	
817-828 mos	
829-840 mos	
841-852 mos	
853-864 mos	
865-876 mos	
877-888 mos	
889-900 mos	
901-912 mos	
913-924 mos	
925-936 mos	
937-948 mos	
949-960 mos	
961-972 mos	
973-984 mos	
985-996 mos	
997-1008 mos	
1009-1020 mos	
1021-1032 mos	
1033-1044 mos	
1045-1056 mos	
1057-1068 mos	
1069-1080 mos	
1081-1092 mos	
1093-1104 mos	
1105-1116 mos	
1117-1128 mos	
1129-1140 mos	
1141-1152 mos	
1153-1164 mos	
1165-1176 mos	
1177-1188 mos	
1189-1200 mos	
1201-1212 mos	
1213-1224 mos	
1225-1236 mos	
1237-1248 mos	
1249-1260 mos	
1261-1272 mos	
1273-1284 mos	
1285-1296 mos	
1297-1308 mos	
1309-1320 mos	
1321-1332 mos	
1333-1344 mos	
1345-1356 mos	
1357-1368 mos	
1369-1380 mos	
1381-1392 mos	
1393-1404 mos	
1405-1416 mos	
1417-1428 mos	
1429-1440 mos	
1441-1452 mos	
1453-1464 mos	
1465-1476 mos	
1477-1488 mos	
1489-1500 mos	
1501-1512 mos	
1513-1524 mos	
1525-1536 mos	
1537-1548 mos	
1549-1560 mos	
1561-1572 mos	
1573-1584 mos	
1585-1596 mos	
1597-1608 mos	
1609-1620 mos	
1621-1632 mos	
1633-1644 mos	
1645-1656 mos	
1657-1668 mos	
1669-1680 mos	
1681-1692 mos	
1693-1704 mos	
1705-1716 mos	
1717-1728 mos	
1729-1740 mos	
1741-1752 mos	
1753-1764 mos	
1765-1776 mos	
1777-1788 mos	
1789-1800 mos	
1801-1812 mos	
1813-1824 mos	
1825-1836 mos	
1837-1848 mos	
1849-1860 mos	
1861-1872 mos	
1873-1884 mos	
1885-1896 mos	
1897-1908 mos	
1909-1920 mos	
1921-1932 mos	
1933-1944 mos	
1945-1956 mos	
1957-1968 mos	
1969-1980 mos	
1981-1992 mos	
1993-2004 mos	
2005-2016 mos	
2017-2028 mos	
2029-2040 mos	
2041-2052 mos	
2053-2064 mos	
2065-2076 mos	
2077-2088 mos	
2089-2100 mos	
2101-2112 mos	
2113-2124 mos	
2125-2136 mos	
2137-2148 mos	
2149-2160 mos	
2161-2172 mos	
2173-2184 mos	
2185-2196 mos	
2197-2208 mos	
2209-2220 mos	
2221-2232 mos	
2233-2244 mos	
2245-2256 mos	
2257-2268 mos	
2269-2280 mos	
2281-2292 mos	
2293-2304 mos	
2305-2316 mos	
2317-2328 mos	
2329-2340 mos	
2341-2352 mos	
2353-2364 mos	
2365-2376 mos	
2377-2388 mos	
2389-2400 mos	
2401-2412 mos	
2413-2424 mos	
2425-2436 mos	
2437-2448 mos	
2449-2460 mos	
2461-2472 mos	
2473-2484 mos	
2485-2496 mos	
2497-2508 mos	
2509-2520 mos	
2521-2532 mos	
2533-2544 mos	
2545-2556 mos	
2557-2568 mos	
2569-2580 mos	
2581-2592 mos	
2593-2604 mos	
2605-2616 mos	
2617-2628 mos	
2629-2640 mos	
2641-2652 mos	
2653-2664 mos	
2665-2676 mos	
2677-2688 mos	
2689-2700 mos	
2701-2712 mos	
2713-2724 mos	
2725-2736 mos	
2737-2748 mos	
2749-2760 mos	
2761-2772 mos	
2773-2784 mos	
2785-2796 mos	
2797-2808 mos	
2809-2820 mos	
2821-2832 mos	
2833-2844 mos	
2845-2856 mos	
2857-2868 mos	
2869-2880 mos	
2881-2892 mos	
2893-2904 mos	
2905-2916 mos	
2917-2928 mos	
2929-2940 mos	
2941-2952 mos	
2953-2964 mos	
2965-2976 mos	
2977-2988 mos	
2989-3000 mos	

OTHER FEATURES OF PEDS

- Can be used from birth to 8 years of age
- Takes about 2 minutes to administer and score if conducted as an interview. Less time is needed if parents complete the brief questionnaire in waiting or exam rooms or at home prior to an encounter.
- Has high sensitivity and identifies 74% to 80% of children with disabilities—in keeping with standards for developmental screening tests and commensurate with the accuracy of measures that take much longer to administer.
- Has high specificity. 70% to 80% of children without disabilities are identified as typically developing—also in keeping with standards for screening tests.
- Can be used by parents with differing levels of education, socioeconomic status, etc.
- Is written at the fifth-grade reading level, which ensures that almost all parents can read and respond independently to the items.
- Has a longitudinal recording form for summarizing surveillance and promotion activities. This facilitates optimal long-term management of children's psychosocial needs.
- Validated on more than 771 children across the US in various settings, pediatric offices, outpatient clinics, day care centers, and schools.
- Standardized on a national sample of 971 families from various backgrounds, including levels of socioeconomic status and varying ethnicity.
- Promotes confident and accurate decision-making about developmental and behavioral issues.
- Has English and Spanish versions. Versions in other languages can be easily developed due to PEDS' brevity.
- Is highly reliable and can be administered by a range of professionals and paraprofessionals including office staff.
- Requires minimal training. New users need only read this brief scoring and administration guide.
- Can be self-administered by parents in waiting areas, exam rooms, or at home, prior to a visit.
- Has a per encounter cost of about 60 cents, or about 35 cents if the score form is used longitudinally.
- Has been peer-reviewed. Supporting research includes the following papers by Dr. Frances Page Glascoe and colleagues at Vanderbilt University:

Comprehensive PEDS Manual

A complete manual for PEDS, titled *Collaborating With Parents: Using Parents' Evaluations of Developmental Status in Screening, Surveillance and Promotion* was published in July of 1998.

The manual gives detailed guidance on using PEDS in educational programs and health care settings. It describes effective techniques for parent education, includes informational handouts for parents, and lists sources for other materials.

Also provided are several second-stage screening tests, reviews and ordering information on other second-stage screens, advice on how to deliver difficult news and where to find services for children and parents. Finally, the manual presents complete standardization, reliability, validity, and accuracy research on PEDS.

The author, Dr. Frances Page Glascoe, is happy to assist researchers interested in studying PEDS. She can be reached via e-mail: Frances.P.Glascoe@Vanderbilt.edu fax: 615-936-0256; phone: 615-836-0249 or by mail: Vanderbilt University, Department of Pediatrics, 426 Medical Center South, Nashville, TN 37232.

Glascoe FP. Parents' concerns about children's development: prescreening technique or screening test? *Pediatrics*. 1997;99:522-528.

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Glascoe FP. It's not what it seems. The relationship between parents' concerns and children's cognitive status. *Clinical Pediatrics*. 1994;33: 292-298.

Glascoe FP, MacLean WE, Stone WL. The importance of parents' concerns about their child's behavior. *Clinical Pediatrics*. 1991;30:8-11.

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Glascoe FP. Do parents discuss concerns about children's development with health care providers? *Ambulatory Child Health*. 1997;2:349-356.

ORDERING INFORMATION

Please note that 5% of net profits are donated to promote research on early detection of disabilities in developing countries.

Item	Cost	Quantity	Amount
Complete Set: 1 Brief Administration and Scoring Guide, 1 pad of 50 PEDS Response and 1 pad of 50 Score/Interpretation Forms	\$30.00		
Brief Administration and Scoring Guide	3.50		
Brief Administration and Scoring Guide for English-speaking professionals working with Spanish-speaking parents	3.50		
PEDS Response Forms (pad of 50)	15.00		
PEDS Score/Interpretation Forms (pad of 50)	15.00		
PEDS Response Form for Spanish-speaking parents (pad of 50)	15.00		
<i>bulk order discount: screens 1,000 children</i> 20 pads of 50 Response Forms, 20 pads of 50 Score/Interpretation Forms, and 20 Brief Scoring and Administration Guides	500.00		
<i>Collaborating With Parents</i> (comprehensive PEDS manual)	69.95		
SUBTOTAL			
TN residents must add applicable sales tax			
Shipping and handling (all orders shipped express mail) 11% of total, \$8.99 minimum			
TOTAL			

Send to (please print) _____

daytime phone _____

Purchase Order Number _____
(please attach appropriate paperwork)

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billing address (if different from shipping address)

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PEDS RESPONSE FORM

Child's Name _____ Parent's Name _____

Child's Birthday _____ Child's Age _____ Today's Date _____

1. Please list any concerns about your child's learning, development and behavior.

2. Do you have any concerns about how your child talks and makes speech sounds?

Circle one: No Yes A little COMMENTS:

3. Do you have any concerns about how your child understands what you say?

Circle one: No Yes A little COMMENTS:

4. Do you have any concerns about how your child uses his or her hands and fingers to do things?

Circle one: No Yes A little COMMENTS:

5. Do you have any concerns about how your child uses his or her arms and legs?

Circle one: No Yes A little COMMENTS:

6. Do you have any concerns about how your child behaves?

Circle one: No Yes A little COMMENTS:

7. Do you have any concerns about how your child gets along with others?

Circle one: No Yes A little COMMENTS:

8. Do you have any concerns about how your child is learning to do things for himself/herself?

Circle one: No Yes A little COMMENTS:

9. Do you have any concerns about how your child is learning preschool or school skills?

Circle one: No Yes A little COMMENTS:

10. Please list any other concerns.

Child's Name _____

Specific Decisions _____

PEDS INTERPRETATION FORM

Path A: Two or more significant concerns?

Yes → Two or more concerns about self-help, social, school, or receptive language skills.

No →

Refer for audiological and speech language testing. Use professional judgment to decide if materials are also needed for social work, occupational/physical therapy, mental health services, etc.

Refer for intellectual and educational evaluations. Use professional judgment to decide if speech language, audiological, or other evaluations are also needed.

0-4 mos _____
4-6 mos _____
6-12 mos _____
12-15 mos _____
15-18 mos _____

Path B: One significant concern?

Yes → Screen or refer for screening.

→

If screen is passed, counsel in areas of concern and watch vigilantly.

If screen is failed, refer for testing in area(s) of difficulty.

18-23 mos _____

2 yrs _____

Path C: Nonsignificant concerns?

Yes → Counsel in areas of difficulty and follow up in several weeks.

If unsuccessful, screen for emotional/behavioral problems and refer as indicated. Otherwise refer for parent training, behavioral intervention, etc.

3 yrs _____

4-4 1/2 yrs _____

Path D: Parental difficulties communicating?

Yes → Foreign language barrier?

No →

Use a second screen that directly elicits children's skills or refer for screening elsewhere.

4 1/2-6 yrs _____

6-7 yrs _____

Path E: No concerns?

Yes → Elicit concerns at next checkpoint.

No →

Use PEDS between checkpoints (e.g. sick-or return-visit).

7-8 yrs _____

PEDS SCORE FORM

Child's Name _____

Birthday _____

Find appropriate column for the child's age. Place a checkmark in the appropriate box to show each concern on the PEDS Response Form. See Birth Scoren. Guide for details on categorizing concerns. Shaded boxes are significant predictors of difficulties. Non-shaded boxes are non-significant predictors.

Child's Age:	0-3 mos.	4-5 mos.	6-11 mos.	12-14 mos.	15-17 mos.	18-23 mos.	2 yrs.	3 yrs.	4-4 1/2 yrs.	4 1/2-6 yrs.	6-7 yrs.	7-8 y.
1. Global/Cognitive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Expressive Language and Articulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Receptive Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Fine-Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Gross Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Social-emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Self-help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Count the number of checks in the small shaded boxes and place the total in the large shaded box below.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If the number shown in the large shaded box is 2 or more, follow Path A on PEDS Interpretation Form. If the number shown is exactly 1, follow Path B. If the number shown is 0, count the number of small unshaded boxes and place the total in the large unshaded box below.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If the number shown in the large unshaded box is 1 or more, follow Path C. If the number 0 is shown, consider Path D. If relevant, otherwise follow Path E.

Use of the Pediatric Symptom Checklist to Screen for Psychosocial Problems in Pediatric Primary Care

A National Feasibility Study

Michael S. Jellinek, MD, J. Michael Murphy, EdD; Michelle Little, Maria E. Pagano, EdM, Diane M. Comer, BA; Kelly J. Kelleher, MD, MPH

Background: Routine use of a brief psychosocial screening instrument has been proposed as a means of improving recognition, management, and referral of children's psychosocial morbidity in primary care.

Objective: To assess the feasibility of routine psychosocial screening using the Pediatric Symptom Checklist (PSC) in pediatrics by using a brief version of the checklist in a large sample representative of the full range of pediatric practice settings in the United States and Canada. We evaluated large-scale screening and the performance of the PSC in detecting psychosocial problems by (1) determining whether the prevalence of psychosocial dysfunction identified by the PSC was consistent with findings in previous, smaller samples; (2) assessing whether the prevalence of positive PSC screening scores varied by population subgroups; and (3) determining whether the PSC was completed by a significant proportion of parents from all subgroups and settings.

Patients and Methods: Twenty-one thousand sixty-five children between the ages of 4 and 15 years were seen in 2 large primary care networks: the Ambulatory Sentinel Practice Network and the Pediatric Research in Office Settings network, involving 395 pediatric and family practice clinicians in 44 states, Puerto Rico, and 4 Canadian provinces. Parents were asked to complete a brief questionnaire that included demographic information, history of mental health services, the 35-item PSC, and the number of pediatric visits within the past 6 months.

Results: The overall prevalence rates of psychosocial dysfunction as measured by the PSC in school-aged and preschool-aged pediatric outpatients (13% and 10%, respectively) were nearly identical to the rates that had been reported in several smaller samples (12%-14% among school-aged children and 7%-14% among preschoolers). Consistent with previous findings, children from low-income families were twice as likely to be scored as dysfunctional on the PSC than were children from higher-income families. Similarly, children from single-parent as opposed to those from 2-parent families and children with a past history of mental health services showed an elevated risk of psychosocial impairment. The current study was the first to demonstrate a 50% increase in risk of impairment for male children. The overall rate of completed forms was 97%, well within an acceptable range, and at least 94% of the parents in each sociodemographic subgroup completed the PSC form.

Conclusions: Use of the PSC offers an approach to the recognition of psychosocial dysfunction that is sufficiently consistent across groups and locales to become part of comprehensive pediatric care in virtually all outpatient settings. In addition to its clinical utility, the consistency and widespread acceptability of the PSC make it well suited for the next generation of pediatric mental health services research, which can address whether earlier recognition of and intervention for psychosocial problems in pediatrics will lead to cost-effective outcomes.

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Editor's Note: I get depressed every time I'm reminded that more than 1 in every 10 children suffer from a psychosocial problem.

Catherine D. DeAngelis, MD

From the Child Psychiatry Service, Massachusetts General Hospital, Boston (Dr Jellinek and Murphy and Ms Little and Pagano), and Child Services Research and Development, University of Pittsburgh, Pittsburgh, Pa (Ms Comer and Dr Kelleher).

CHILDHOOD psychosocial dysfunction, considered a "new morbidity" 20 years ago, has become widely acknowledged as the most common chronic condition of children and adolescents.^{1,2} Epidemiological studies report that 14% to 20% of all school-aged US

children and 13% of preschoolers have an emotional and/or behavioral disorder.^{1*} The rates of psychosocial impairment seem to be higher in risk groups such as low-income, single-parent households.

Pediatricians have long been an important first resource for parents who are worried about their children's behavioral problems.³ With the advent of managed and especially capitated health systems,^{4,5} primary care providers assume an even greater "gatekeeping" responsibility to identify, manage, and refer children with emotional and/or behavioral disorders.⁶ Yet, recent studies estimate that only about

PARTICIPANTS AND METHODS

SITE AND SAMPLE

The study was conducted in 2 large practice-based primary care research networks: the Pediatric Research in Office Settings (PROS) network¹² and the Ambulatory Sentinel Practice Network (ASPN).¹³ The PROS is a pediatric network that was established in 1986 and currently comprises more than 1300 clinicians from more than 475 practices in all 50 states and the Commonwealth of Puerto Rico. The ASPN is a family medicine network that was established in 1978 and currently consists of 125 practices, with about 750 clinicians from 38 states and 6 Canadian provinces. Eighty-nine percent of PROS clinicians are pediatricians, 10% are nurse practitioners, and 1% are physician assistants. Eighty-five percent of ASPN clinicians are family physicians, 7% are nurse practitioners, and 8% are physician assistants. The ASPN also collaborated with 2 regional networks to expand the number of participating family physicians. The characteristics of the Wisconsin Research Network and the Minnesota Academy of Family Physicians Research Network are similar to those of ASPN and contributed 38 and 24 participating clinicians, respectively.

Clinicians who had previously completed PROS or ASPN research studies and were not participating in other major studies were recruited by network coordinators and staff. After agreeing to participate, all clinicians completed the practice questionnaire assessing practice structure, attitudes, and training related to psychosocial problems. After completion of the practice questionnaire, practices received training materials for the study including a videotape and written instructions.

Three hundred ninety-five pediatric and family practice clinicians in 44 states, Puerto Rico, and 4 Canadian provinces participated in data collection for the Child Behavior Study (principal investigator, K.J.K.). Prior research from both ASPN and PROS confirms the comparability of patients, clinicians, and practices participating in primary care networks studies with those identified in national samples.^{14,15} A survey conducted as part of the Child Behavior Study¹⁶ showed no difference in demographic factors, practice characteristics, or attitudes toward psycho-

social problems among participating pediatricians and a random sample of primary care pediatricians from the American Academy of Pediatrics. Pediatricians from the American Academy of Pediatrics, however, had minimally higher rates of patients with either private insurance or no insurance.

All children between the ages of 4 and 15 years and their parents or guardians who visited the clinician's office for health care during the practice's enrollment period were approached in the waiting room for written consent to participate in the study. Procedures and consent forms were approved by institutional review boards affiliated with PROS, ASPN, and the University of Pittsburgh, Pittsburgh, Pa. Each clinician enrolled a consecutive sample of about 60 children aged 4 to 15 years presenting for non-emergent visits in the presence of a parent or caregiver.

All study materials were mailed to the research networks for inspection, verification, and coding. Data entry was contracted out to an independent organization.

MEASURES

Sociodemographic Variables

Data on each child's age, sex, racial/ethnic background, health status, history of own and parental use of mental health services, parental marital status, parental education, and use of Medicaid insurance were recorded on the clinician visit questionnaire. The highest level of education for either parent was used as an estimate of SES. Parents with a high school education or less were coded as low SES; parents with some college, a college degree, or a technical school degree were coded as middle SES; and parents with a graduate or professional degree were coded as high SES.

Psychosocial Functioning

Psychosocial functioning was assessed using the PSC (Figure). The PSC consists of 35 items that are rated as never, sometimes, or often present (scored 0, 1, and 2, respectively). Item scores are summed and the total score is recoded into a dichotomous variable indicating psychosocial impairment. For children aged 6 through 16 years, the cutoff score is 28 or higher. For 4- and 5-year-old children, the PSC cutoff is 24 or higher.^{10,19}

50% of these children are identified by their primary care physicians and that, once identified, only a fraction of them receive appropriate mental health treatment.^{9,12,15}

Despite the growing burden of psychosocial morbidity, pediatricians do not receive adequate training concerning psychosocial problems, are hesitant to attach potentially deleterious labels to children,¹⁵ do not have time during office visits to address psychosocial needs, and may have limited access to mental health referral networks.¹² Recent efforts such as the American Board of Pediatrics increasing ambulatory and behavioral training requirements⁴ and publications such as *Bright Futures*¹⁶ and the *Diagnostic and Statistical Manual for Primary Care*¹⁷ may help to increase awareness of psychosocial morbidity over the long term, but now primary care pediatricians still

struggle to provide psychosocial services.^{4,16,17} Given the focus on productivity and profitability, the move to managed care approaches in medicine has created additional pressure for pediatric clinicians to limit attention on psychosocial problems.

One approach to facilitating recognition and referral of psychosocial problems is to use a parent-completed screening questionnaire as part of routine primary care visits.¹⁸ The Pediatric Symptom Checklist (PSC) was developed for this purpose. The PSC is a 1-page questionnaire of children's emotional and behavioral problems that reflects parents' impressions of their children's psychosocial functioning. Cutoff scores for school-aged and pre-school-aged children indicating clinical levels of dysfunction have been empirically derived using receiver operator characteristic analyses in studies comparing the

Please mark under the heading that best fits your child

	Never	Sometimes	Often
1. Complains of aches or pains			
2. Spends more time alone			
3. Tires easily, little energy			
4. Fidgety, unable to sit still			
5. Has trouble with a teacher			
6. Less interested in school			
7. Acts as if driven by a motor			
8. Daydreams too much			
9. Distracted easily			
10. Is afraid of new situations			
11. Feels sad, unhappy			
12. Is irritable, angry			
13. Feels hopeless			
14. Has trouble concentrating			
15. Less interest in friends			
16. Fights with other children			
17. Absent from school			
18. School grades dropping			
19. Is down on himself or herself			
20. Visits doctor, with doctor finding nothing wrong			
21. Has trouble sleeping			
22. Worries a lot			
23. Wants to be with you more than before			
24. Feels he or she is bad			
25. Takes unnecessary risks			
26. Gets hurt frequently			
27. Seems to be having less fun			
28. Acts younger than children his or her age			
29. Does not listen to rules			
30. Does not show feelings			
31. Does not understand other people's feelings			
32. Teases others			
33. Blames others for his or her troubles			
34. Takes things that do not belong to him or her			
35. Refuses to share			

Pediatric Symptom Checklist

performance of the PSC with other validated questionnaires and clinicians' assessments of children's overall functioning.^{19,20} In validity studies, PSC case classifications agreed with case classifications on the Children's Behavior Checklist (CBCL), clinicians' Global Assessment Scale ratings of impairment, and the presence of psychiatric disorder in a variety of pediatric and subspecialty settings representing diverse socioeconomic backgrounds.^{19,21} When compared with the Children's Global Assessment Scale scores in both middle- and lower-income samples, the PSC has shown high rates of overall agreement (79% and 92%), sensitivity (95% and 88%), and specificity (68% and 100%).^{21,22} Studies using the PSC have found prevalence rates of psychosocial impairment in middle-class or general settings that are quite comparable to national estimates of psychosocial problems.^{19,23} More recently, efforts are under way to develop specific subscales of the PSC for use in identification of attentional, internalizing (depression/anxiety), and behavior problems (W. Gardner MD, unpublished data, 1998).

Previous studies using a variety of measures have consistently shown that the prevalence of psychosocial impairment varies considerably based on several socio-demographic risk factors, and research with the PSC has paralleled many of these findings. For example, low socioeconomic status (SES),²⁶ living with a single parent,²⁷ parental mental illness,²⁸ family discord,²⁹ the child's temperamental characteristics, and male sex^{30,31} have all been shown to increase the probability of psychosocial dysfunction. Consistent with these findings, studies using the PSC have shown the prevalence of child psychosocial dysfunction to be 2 to 3 times higher in children with low family incomes, single parents,²³ or mentally ill parents.²³

Some investigators have recommended that the PSC should be considered "basic office equipment" in pediatrics¹⁸ and others have argued that the PSC should become a mandated part of all well-child visits in managed care settings or large programs like Medicaid Early Periodic Screening Diagnosis and Testing.²⁴ Routine use of a brief screening instrument like the PSC could provide a counterbalance to the previously mentioned pressures toward underrecognition, but such recommendations presuppose that the use of the PSC would be feasible across the full range of practice settings among diverse populations and regions.

Previous studies have shown that the PSC is a feasible method of early detection in selected pediatric sites, but these findings have been limited to samples of less than 500 patients. Sample sizes have been too small to investigate systematically the feasibility of using the PSC to screen for dysfunction in diverse types of pediatric practices that use varying methods of insurance reimbursement, are located in a variety of geographic regions in the United States, and that include family practice clinicians.

Our study assessed the feasibility of routine psychosocial screening with the PSC in a large national sample involving more than 21 000 pediatric outpatients drawn from the practices of 395 primary care clinicians representing 44 states, Puerto Rico, and 4 Canadian provinces. Specifically, the assessment of the PSC's feasibility was operationalized by examining whether (1) in the current sample the overall prevalence of positive PSC screening scores was consistent with previously reported findings, (2) the prevalence of positive PSC screening scores varied by sociodemographic subgroups as in previous studies, and (3) the use of the PSC was feasible for use with the full range of parents as evidenced by high and comparable rates of questionnaire completion across groups.

RESULTS

SAMPLE

Twenty-two thousand fifty-nine preschool-aged and school-aged children met the initial criteria for inclusion and were enrolled in the study. No differences in age or sex were detected in a comparison of participating children with non-participating children. Children in the western United States were slightly more likely to participate. Of participating

Table 1. Sociodemographics, Health Status, and Use of Mental Health Services of Preschoolers, School-aged Children and Adolescents, and the Total Sample*

	Total Sample, Aged 4-15 y (N = 21 065)	Preschoolers, Aged 4-5 y (n = 5573 [26% of Total])	School-aged Children and Adolescents, Aged 6-15 y (n = 15 492 [74% of Total])
Sex			
M	10 477 (50)	2760 (50)	7717 (50)
F	10 588 (50)	2813 (50)	7775 (50)
Parent education			
Low	4845 (23)	1336 (24)	3509 (23)
Middle	11 677 (55)	3107 (56)	8570 (55)
High	4543 (22)	1130 (20)	3413 (22)
Race			
White	17 346 (82)	4466 (80)	12 880 (83)
African American	1356 (6)	442 (8)	914 (6)
Hispanic	1648 (8)	474 (8)	1174 (8)
Asian American	397 (2)	104 (2)	293 (2)
Native Alaskan	146 (0.7)	34 (0.6)	112 (0.7)
Other	172 (0.8)	53 (1)	119 (0.8)
Minority status	3719 (18)	1107 (20)	2612 (17)
Parental marital status			
2 Parents living together	15 073 (72)	4099 (74)	10 974 (71)
Single parent	5992 (28)	1474 (26)	4518 (29)
Health status			
Good or very good	20 265 (96)	5381 (97)	14 884 (96)
Fair or poor	800 (4)	192 (3)	608 (4)
Ever received mental health services	3758 (18)	432 (8)	3326 (22)
Medicaid insurance	3749 (18)	1191 (21)	2558 (17)

*Data are presented as number (percentage)

children, 665 (3%) had PSCs that were missing 5 or more items and 339 (1.5%) had other missing data, leaving a final sample of 21 065 children.

As shown in **Table 1**, of the final sample of children, 5573 (14%) were of preschool age, 10 477 (50%) were male, 3719 (18%) were from minority backgrounds, and 5992 (28%) were from single-parent households (separated, divorced, or deceased spouse). Of the total sample, 4543 children (22%) had at least 1 parent with a graduate or professional degree; 11 677 (55%) had at least 1 parent with some college, a college degree, or a technical school diploma or less. Three thousand seven hundred forty-nine (18%) were covered by Medicaid insurance. Eight hundred children (4%) were reported by their parents to have fair or poor health. Three thousand seven hundred fifty-eight (18%) had a history of using mental health services.

PSYCHOSOCIAL FUNCTIONING AND RISK FACTOR GROUPS

As presented in **Table 2**, the PSC identified 2077 (13%) of the school-aged children as having psychosocial dysfunction, a prevalence rate that is consistent with the rates of 12% to 14% found in previous PSC studies in middle- or mixed-income samples. Among preschoolers, the prevalence of psychosocial dysfunction was 10% (580/5573), the mean of previous reported prevalence rates (7% and 14%) in 2 small samples that used the PSC with 4- and 5-year-olds.^{19,21} Analysis of PSC case rates by region showed that the rate of psychosocial dysfunction was

10% in the northeastern practices, 13% in southern and western practices, 15% in midwestern practices, and 16% in Canadian practices ($P < .001$). **Table 2** also presents the results of previous studies of the PSC in pediatric outpatient settings^{19,21,24} in comparison with those of the current study.

As in previous studies, rates of psychosocial dysfunction were about 2 times higher for low SES children (parents have a high school education or less) than for high SES children (at least 1 parent has a graduate or professional degree) both for school-aged children (20% vs 9%) and for preschoolers (15% vs 6%). Results were almost as consistent with regard to the risk factor of coming from a single-parent family. In all previous studies with the PSC, children from single-parent families were more likely to be coded as dysfunctional than children from 2-parent families, although the increase in risk ranged from 10% to 5-fold. In the current study, for both school-aged and preschool-aged children, the increase in risk was just more than double (22% vs 10% and 17% vs 8%, respectively).

As indicated in **Table 3**, both poverty and single-parent status were significantly associated with higher mean PSC scores. The mean PSC score of children from single-parent households was 4 points higher (18.1 [SD = 11.3]) than the mean PSC score of children from 2-parent families (13.9 [SD = 9.2], $t = -25.8$, $df = 9315.8$, $P < .001$). Low-income children also averaged 4 points higher on the PSC (17.2 [SD = 11.2]) compared with children of middle- (13.2 [SD = 9.0]) or higher-income status (14.9 [SD = 9.7], $F = 195.66$, $df = 221.062$, $P < .001$).

Table 2. Prevalence of Psychosocial Dysfunction in Children Aged 4 to 16 Years in Medical Outpatient Settings*

	Jellinek et al. ¹⁴ (N = 206)	Jellinek et al. ¹⁵ (N = 300)	Murphy et al. ¹² (N = 123)	Rauch et al. ¹⁴ (N = 377)	Murphy et al. ¹⁵ (N = 379)	Pagano et al. ¹⁶ (N = 1117)	Little et al. ¹⁷ (N = 115)	Kelleher et al., 1996 (N = 15 492)	Kelleher et al., 1996 (N = 5573)
Setting	Suburban practice	Suburban/ urban HMO	Dermatology health center	Public health practices	Public health clinic	Suburban clinic	Outpatient practice	Network practices	Network practices
Age range, y	6-12	6-12	6-12	6-12	6-12	4-5	4-5	6-15	4-5
PSC case rate	12 (25/206)	14 (43/300)	22 (27/123)	13 (48/377)	11 (40/379)	7 (8/117)	14 (16/115)	13 (2077/15 492)	10 (580/5573)
Socioeconomic status									
Low	19 (4/21)	...	22 (11/50)	19 (16/83)	...	...	27 (3/11)	20 (715/3509)†	15 (203/1336)†
Lower/middle	8 (4/48)	24 (10/42)‡	25 (9/36)	9 (14/152)	...	...	20 (4/20)	13 (1072/8570)	10 (305/3107)
Upper/middle	8 (7/90)	13 (38/258)	10 (1/10)	5 (4/78)	...	...	13 (8/51)	9 (290/3413)	6 (72/1130)
Parental marital status									
Single parent	...	18 (14/76)	34 (26/77)	...	18 (14/76)§	10 (2/20)	...	22 (1004/4518)†	17 (249/1474)†
Parents living together	...	13 (11/29)	7 (3/46)	...	8 (26/307)	8 (6/72)	...	10 (1073/10 974)	8 (426/5141)
History of therapy									
History	...	89 (17/19)†	100 (2/2)	26 (8/31)	29 (6/21)†	0 (0/1)	...	37 (1223/3226)†	36 (154/432)†
No history	...	38 (11/29)	55 (12/22)	12 (40/346)	9 (34/362)	8 (8/104)	...	7 (854/12 166)	8 (426/5141)
Sex									
M	15 (17/111)	17 (25/149)	31 (16/52)	15	10 (21/203)	12 (7/60)§	9 (5/53)	17 (1347/7717)†	12 (333/2760)†
F	8 (8/95)	13 (18/140)	16 (11/71)	11	11 (19/176)	2 (1/57)	18 (11/62)	9 (730/7775)	9 (247/2813)

*All studies used the Pediatric Symptom Checklist (PSC). Data are presented as percentage (number/total number). Ellipses indicate not applicable; HMO, health maintenance organization.

† $P < .001$.

‡ $P < .01$.

§ $P < .05$.

Table 3. Comparison of Mean Pediatric Symptom Checklist Scores Within Selected Risk Factor Groups

	No. of Patients	Mean (SD) [Range]
Total sample	21 065	15.1 (10.0) [0-65]
Sex		
M	10 477	16.6 (10.5) [0-63]*
F	10 588	13.5 (9.3) [0-65]
Age/sex		
Preschool boys	2760	14.5 (8.0) [0-48]*
Preschool girls	2813	12.8 (7.7) [0-51]
School-aged boys	7717	17.3 (11.2) [0-63]*
School-aged girls	7775	13.8 (9.8) [0-65]
Parental education		
Low	4845	17.2 (11.2) [0-65]*
Middle	11 677	14.9 (9.7) [0-64]
High	4543	13.2 (9.0) [0-54]
Parental marital status		
Parents living together	15 073	13.9 (9.2) [0-64]*
Single parent	5992	18.1 (11.3) [0-65]

* $P < .001$.

Previous research had demonstrated consistent significant associations between a history of mental health treatment and higher scores on the PSC. The current study not only confirmed this finding for school-aged children, but suggested that it was even stronger than had previously been reported, with a 4- to 5-fold increase in risk rather than the 2- to 3-fold increase that had been noted in the smaller previous studies (37% vs 7%). Similarly, for preschoolers, a history of mental health services nearly quadrupled the likelihood of psychosocial impairment as measured by the PSC (36% vs 8%).

Although previous studies had shown mixed results in terms of sex differences, the current study demonstrated that boys were significantly more likely to have higher PSC scores than girls for both school-aged (17% vs 9%) and preschool-aged children (12% vs 9%). As indicated in Table 3, the mean PSC score of school-aged boys was more than 3 points higher than the mean PSC score of school-aged girls (17.3 [SD = 11.2] compared with 13.8 [SD = 9.8], respectively). The difference between boys and girls seemed to be somewhat less pronounced in the preschool years, where the mean PSC score for boys was about 1½ points higher than the mean for girls (14.5 [SD = 8.0] compared with 12.8 [SD = 7.7]; $t = -8.0$, $df = 5571.0$, $P < .001$).

PARENTS' COMPLETION OF THE PSC

The feasibility of using the PSC was assessed by comparing the percentage of forms that were returned with at least 30 of the 35 items completed (no more than 5 missing items) across sociodemographic and risk groups. The overall rate of completed forms was well within an acceptable range for all groups assessed, with at least 94% of the parents in each group fully completing the PSC form (missing data on no more than 5% of the forms). In the sample as a whole, 97% of children screened had completed PSCs. No significant differences in completion rates were found by medical specialty (either family or pediatric practice), geographic region, or managed vs non-managed care plan membership. Parents' completion rates were slightly lower in urban locales (95% vs 98% [rural] and 98% [suburban], $P < .001$), for low SES parents (95% vs 98% [middle SES parents] and 98% [high SES parents], $P < .001$), among those parents receiving Medicaid (91% vs 98% of those not receiving Med-

icaid; $P < .001$), and among minority parents (94% vs 98% among non-minority parents; $P < .001$).

COMMENT

Parents of more than 21 000 children aged 4 to 15 years seen in 2 large primary care networks involving 395 primary care clinicians in 44 states, Puerto Rico, and 4 Canadian provinces voluntarily filled out the PSC. Unlike previous studies using the PSC, screening was successfully implemented by clinic personnel without the aid of research assistants or other personnel trained specifically for study purposes. Ninety-seven percent of participating parents completed the PSC. The successful implementation of psychosocial screening using already existing personnel and the high rate of screening completion indicates that the PSC offered a feasible method of screening 4- to 15-year-old children attending both pediatric and family medicine practices nationwide.

The prevalence of psychosocial dysfunction in school-aged children in this nationally representative sample was 13%, a rate that is virtually identical to rates of impairment reported in previous studies using the PSC in outpatient mixed SES samples.¹⁹ The rate of impairment among preschool-aged children (10%) was also comparable to rates in previous studies of smaller samples. There has been some variability in the prevalence of preschool psychosocial dysfunction as measured by the PSC.^{20,21} A recent study of a low-income, predominantly Mexican American population²⁰ showed a rate of 7% among 4- and 5-year-olds, compared with 14% among a suburban, predominantly middle-income sample and 11% in the current sample. This variability may be accounted for by several factors. The lower prevalence rate found in the small sample of Mexican American preschoolers may have been a result of underreporting by a population of parents whose native language and cultural expectations were different. Previous PSC studies of preschoolers have used very small samples of about 100 subjects, which may have contributed to artificially high or low prevalence rates. In accordance with previous studies using the PSC, poverty and coming from a single-parent family doubled the risk of psychosocial dysfunction. Children with a history of mental health treatment were 4 to 5 times more likely to have high PSC scores.

This was the first study of the PSC with school-aged children to document the significantly higher rate of dysfunction for boys, a finding that was also significant for preschoolers. In both age groups, boys were about 1½ times more likely to be coded as cases on the PSC. These results are consistent with epidemiological findings showing a higher prevalence of parent-identified behavioral problems and a higher rate of mental health referral in male children and adolescents than in female children and adolescents.²² Previous studies also suggest that girls are more likely than boys to have internalizing difficulties (ie, anxiety and depression), which may not be as readily identified and/or reported by parents or teachers.²³

The PSC has performed as predicted in 8 published primary care studies including the current sample of more than 21 000 children. Results of these studies have con-

seen in primary care have significant levels of psychosocial problems.

Given the high rates of unrecognized, untreated psychosocial problems in children, the PSC could play an important role in comprehensive care and health supervision. If the PSC scores are high, the physician may spend a few minutes with the parents going over the items they checked off to affirm validity and assess severity. This information may help the physician facilitate a discussion of the child's major areas of functioning (family, school, activities, and mood states), notable stressors (maternal depression or parental discord), and risk factors. The physician may then determine the need for pediatric follow-up to reassess impairment, parental guidance, or mental health referral.

Facing a rising prevalence of emotional and behavioral problems and limitations on reimbursement within the managed health care system, pediatricians may wish to screen and spend available time on those children with serious impairment. While the PSC offers an approach to identifying the growing number of children with psychosocial dysfunction, trials of screening and intervention will be necessary to assure improved outcomes for children with emotional and behavioral disorders as well as to assess the cost offset of enhanced care.

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Announcement

1999 Certifying Examinations of the American Board of Pediatrics: Adolescent Medicine Subspecialty Examination*

Examination Date: November 15, 1999. Registration for first-time applicants: February 1, 1999, through April 30, 1999 (postmarked). Registration for reregistrants: March 15, 1999, through June 15, 1999 (postmarked).

*If you are applying through the ABIM for the 1999 Adolescent Medicine Certifying Examination, you must contact ABIM for registration dates.

You must contact the ABP for application material. Each application will be considered individually and must be acceptable to the Subboard. The eligibility requirements may be obtained by contacting the American Board of Pediatrics, 111 Silver Cedar Ct, Chapel Hill, NC 27514; telephone: 919-929-0461, fax: 919-929-9255; or through the ABP web site: <http://www.abp.org>.

Pediatric Symptom Checklist: Screening school-age children for psychosocial dysfunction

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The Pediatric Symptom Checklist (PSC) is a 35-item screening questionnaire that is completed by parents and designed to help pediatricians in outpatient practice identify school-age children with difficulties in psychosocial functioning. The current study assessed the validity of the PSC by screening 300 children in two pediatric practices, a middle-class group practice and an urban health maintenance organization. Validity was established by comparing the results of PSC screening of 48 children with in-depth interview assessments and pediatricians' ratings. Results indicate that the PSC has a specificity of 0.68 and a sensitivity of 0.95. The screening process was well accepted by parents and pediatricians. Several children whose pediatricians' ratings had indicated adequate functioning were identified by the PSC as having substantial psychosocial dysfunction and requiring further evaluation. (*J PEDIATR* 1988;112:201-9)

One approach to focusing the limited time pediatricians can devote to psychosocial problems would be a screening procedure that would quickly, economically, and accurately select those school-age children who might benefit from further attention.¹ Although information concerning psychosocial functioning can be gathered directly from the child or teachers by means of either a questionnaire or an interview, parent-completed questionnaires probably provide the optimal combination of accuracy and efficiency of administration.² With the same conceptual approach as other pediatric screening procedures, a psychosocial screening questionnaire could alert the pediatrician to those school-age children who have significant psychosocial dysfunction. The pediatrician, rather than depending largely on parental complaints of serious problems, would

then have an additional, more objective basis for further evaluation or referral and could allocate time appropriately by taking the time currently spent on a nonspecific psychosocial review of many emotionally well children and

PSC	Pediatric Symptom Checklist
CGAS	Children's Global Assessment Scale
DICA-P	Diagnostic Interview for Children and Adolescents, parent report
DSM-III	<i>Diagnostic and Statistical Manual of Mental Disorders</i> —third edition
LES	Life Events Scale
HMO	Health maintenance organization
ROC	Receiver Operator Characteristic

focusing it on the evaluation of children identified by the screening instrument.

The Pediatric Symptom Checklist is a 35-item questionnaire designed to be completed in the pediatric waiting room by parents of 6- to 12-year-old children (Table 1). The PSC was developed^{3,4} because other questionnaires were too long, difficult to score, hard to interpret, or did not have a cutoff score for screening purposes.^{5,6} Although

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Pediatric Symptom Checklist*

Use mark under the heading that best fits your child:

	Never	Sometimes	Often
Complains of aches or pains			
Spends more time alone			
Tires easily, little energy			
Fidgety, unable to sit still			
Has trouble with a teacher			
Less interested in school			
Acts as if driven by a motor			
Daydreams too much			
Distracted easily			
Is afraid of new situations			
Feels sad, unhappy			
Is irritable, angry			
Feels hopeless			
Has trouble concentrating			
Less interest in friends			
Fights with other children			
Absent from school			
School grades dropping			
Blame on himself or herself			
Sees physician, but physician finds nothing wrong			
Trouble with sleeping			
Worries a lot			
Wants to be with you more than before			
Feels he or she is bad			
Takes unnecessary risks			
Gets hurt frequently			
Seems to be having less fun			
Acts younger than children his or her age			
Does not listen to rules			
Does not show feelings			
Does not understand other people's feelings			
Teases others			
Blames others for his or her troubles			
Takes things that do not belong to him or her			
Refuses to share			

for a screening instrument provide detailed information and who was missed. In determining the presence intrinsic to validating, must be some set of well-accepted, universal psychosocial disorders. It is to cross-validate numerous multiple measures or a score may define a score and specificity, the cut scores is an increasing in the screening procedure.

Our study evaluated realizing that school-age results on the PSC dysfunctional on the overall psychosocial psychiatric diagnosis, (stress, (4) to be or have known by their pediatric social disorder.

METHODS

Site and sample. All children of 6- to 12-year-old the pediatricians' waiting collection periods were from this study until from the two sites (a population serving an ethnogeneuous group of families). The PSC was self-administering the answers point for "Sometimes." points were then simplified score was equal to or greater than 10. Parents of children who were invited to join in until 28 families, 14 participate. A comparison each site, were randomly the PSC cutoff point.

Consent. Research procedures of the study were completely voluntary. Parents were told about the interview whether they were allowed sampling pool as potential obtained at the time of interview procedures.

*Revised by M. S. Jellinek, MD, and J. M. Murphy, Massachusetts General Hospital, Boston.

Some of the PSC questions pertain to psychiatric diagnosis, neither are specific to a diagnosis nor attempt to measure behavior objectively. The PSC is designed to yield a score that reflects the parent's view of the child's social functioning. Questions focus on the school child's day-to-day life: friends, family, play, school, and general mood. The PSC format of using the total score a cutoff point is based on the premise that a child in need of attention will be either "sometimes" or "often" dysfunctional

in multiple areas of daily life, which will lead to a total score above an empirically defined screening point.

In preliminary studies within outpatient practices,^{1,2} the PSC was compared with a longer, well-established questionnaire that had a defined screening method, the Child Behavior Checklist,^{3,4} which takes about 20 minutes to complete and has a more complex scoring system. These preliminary studies demonstrated that the PSC had an acceptable level of validity and met the practical criteria

for a screening instrument. These studies did not, however, provide detailed information about who was being selected and who was missed. There are no absolute methods for determining the presence of a psychosocial disorder, but intrinsic to validating a psychosocial screening procedure must be some set of standards. Given the lack of a well-accepted, universally agreed-on set of criteria for psychosocial disorders, the current recommended practice is to cross-validate new assessment approaches against multiple measures or standards.^{10,11} Although each measure may define a somewhat different level of sensitivity and specificity, the cumulative impact of multiple measures is an increasing level of confidence in the validity of the screening procedure.

Our study evaluated the validity of the PSC by hypothesizing that school-aged children with positive screening results on the PSC would be more likely (1) to be dysfunctional on the basis of an interview measure of overall psychosocial functioning, (2) to have a serious psychiatric diagnosis, (3) to have experienced high levels of stress, (4) to be or have been in counseling, and (5) to be known by their pediatricians as having a possible psychosocial disorder.

METHODS

Site and sample. All consecutive English-speaking parents of 6- to 12-year-old pediatric outpatients who entered the pediatricians' waiting rooms during defined data collection periods were approached by research assistants from this study until 300 questionnaires were collected from the two sites (a prepaid health maintenance organization serving an ethnically and socioeconomically heterogeneous group of families and a suburban private practice). The PSC was scored by the research assistant by assigning the answers as follows: 0 point for "Never," 1 point for "Sometimes," and 2 points for "Often." The points were then simply added (a positive PSC screening score was equal to or greater than a total score of 28). All parents of children scoring above the PSC cutoff point were invited to join in the interview phase of the study, until 28 families, 14 from each site, had agreed to participate. A comparison group of 20 subjects, half from each site, were randomly selected from those scoring below the PSC cutoff point.¹²

Consent. Research assistants explained the purposes and procedures of the study to the parents. Participation was completely voluntary. After filling out the PSC, parents were told about the interview phase of the study and asked whether they would allow their names to be included in the sampling pool as potential subjects. Written consent was obtained at the time of the interview.

Interview procedures. Structured and semistructured

interviews were conducted by the project director (S.L.) and a psychologist (J.M.M.), both with extensive experience in evaluating and treating children. The full interviews took about 2 hours. The interviewers were unaware of the child's PSC score.

Background data. The Children's Personal Data Inventory,¹³ a 55-item questionnaire, was used to collect background information about the child and family. Data from this questionnaire about the mother's and father's education and occupations were coded according to Hollingshead's four factor index of social position and socioeconomic status.¹⁴ Children who were seeing or had seen mental health professionals, school counselors, or family therapists were considered to be receiving therapy.

Interview measures. The Garmazy Child Interview¹⁵ was chosen as the basis of the clinical interview because it permits the interviewer to know the child well enough to make an informed assessment of the child's psychosocial functioning. Although the original Garmazy interview contained 12 sections, only six were thought to be necessary for the orientation and the age group of our study (school, activities, peer relationships, home and family relationships, dreams and future perspective, and emotions). Information obtained from the child was supplemented by a brief interview with the parent.

Children's Global Assessment Scale. To quantify both interviewers' perceptions of the child's psychosocial functioning, the interviewers rated the child by means of the Children's Global Assessment Scale,¹⁶ which provides a rating scale from 1 (lowest possible level of functioning) to 100 (best possible level of functioning) on the basis of the child's overall functioning and development. Shaffer et al.¹⁶ reported that the mean CGAS rating for oppositional children seen as outpatients was 65.4 and the mean for children on inpatient psychiatric units was 46.0. The authors suggested that a score of 70 or below reflected a clinical range of impairment. Steinhausen¹⁷ recently validated the use of the CGAS as differentiating psychiatrically disordered children when a cutoff score of 70 was used.

Consensus rating. After the interviews, the project director and the psychologist each wrote summaries of the interviews, and these summaries were read by an experienced child psychiatrist (M.S.J.), who then independently rated each child's level of functioning using the CGAS. The summaries were written in as factual and nonsubjective a manner as was practical, and the interviewers' CGAS ratings and rationales were not given. The psychiatrist was also unaware of the child's PSC score. After the psychiatrist's CGAS ratings were completed, the three mental health clinicians reviewed all available clinical information on each child and arrived at an overall

recency and degree of stressfulness and yields a total stress score for each child. Coddington's cutoff score²¹ of 110 for exceptionally high levels of stress was employed for categorical analyses.

RESULTS

Questionnaire sample. To obtain the desired sample size, we approached 317 parents. Eleven parents either refused to complete or could not complete the questionnaires; six PSCs were not scorable because more than three items were omitted. The participation rate was slightly higher in the private practice sample (96%) than in the HMO sample (93%).

The percentage of children with PSC scores of 28 or greater was 17% in the urban HMO practice and 11% in the suburban private practice (chi square = 1.99; $P = 0.16$). In the full sample, the PSC with a cutoff score of 28 or greater flagged 43 of the 300 children, indicating that 14% of the children sampled had scores above the cutoff point, very close to the rate of 12% reported in the previous research with the PSC for a similar outpatient pediatric sample.³

Interview sample. For the interview study, the parents of 25 of the 300 potential subjects (four with PSC-identified cases, 21 with negative PSC scores) declined to allow their names to be included in the sampling for the interview study, resulting in a 92% participation rate. Of the 275 remaining subjects, we needed to invite 56 families (32 with positive and 24 with negative PSC scores) to participate in the study to obtain the objective of 28 children with PSC-identified cases and 20 children with negative PSC scores because some parents decided not to participate or could not be scheduled (participation rates of 88% and 83%, respectively, for children with positive and those with negative scores; 87% overall). The relatively high participation rate for both categories suggested that the obtained interview sample was representative of the sample as a whole.

Sample background data. The interview sample consisted of 26 boys, 16 (62%) of whom had positive PSC scores, and 22 girls, 12 of whom had positive PSC scores (56%) (chi square = 0.04; $P = 0.85$). Fourteen of the children (29%) were from black or Hispanic backgrounds, and seven of these children (50%) had positive PSC scores, whereas the case rate for nonminority children was 62% (chi square = 0.18; $P = 0.67$). These high PSC case rates are the result of the oversampling of children with scores above 28 and are not indicative of the rates that would be found in a "normal" pediatric population. All of the 48 subjects were between 6 and 12 years of age, with a mean age of 8.44 years. The correlation between PSC score and age was $r = 0.04$ ($P = 0.79$). When age, sex, and minority

status were entered into a multiple regression equation, the coefficient of multiple correlation was only $r = 0.06$, and R^2 was 0.004 ($P = 0.98$).

The families of 48 children in the interview sample were from four of the five Hollingshead social classes; none were from the lowest class (social class V), three were from semiskilled backgrounds, 11 from skilled backgrounds, 19 from clerical and minor professional backgrounds, and 15 from professional backgrounds. In the interview sample, PSC scores were significantly associated with exact Hollingshead scores ($r = 0.36$; $P = 0.01$). Although this correlation could indicate a form of class bias in the PSC, analyses reported elsewhere²² have led us to conclude that this correlation was an accurate reflection of the poorer overall functioning of these economically disadvantaged children.

Psychiatric history. Eleven of the children in the sample were receiving some form of psychotherapeutic treatment at the time of their interviews. Ten of these children had positive PSC scores. There were 19 children with a past or present history of some form of psychiatric treatment. Seventeen of these children had positive PSC scores (chi square = 10.52; $P = 0.001$). Although these figures suggest that most of the children who are or have been in psychotherapy have PSC scores above the cutoff point, 18 of the 28 children with positive PSC scores were not currently receiving psychotherapy, and 11 children had never received services.

Table II presents the data on each of the subjects with a history of psychologic treatment or a positive score on any of the five other screening measures (PSC, CGAS, serious psychiatric diagnosis, physician rating, and high stress). Table III presents the data for these measures in summary form.

CGAS scores. The mean CGAS score for children in the interview sample with positive PSC scores was 64.0 ($SD = 9.9$), in comparison with a mean of 77.6 for those with negative PSC score ($SD = 5.4$). Interrater reliability was assessed for the continuous and categorical CGAS scores. The correlation between the two interviewers' CGAS scores was $r = 0.92$; between the summary reader and the two interviewers, it was $r = 0.90$ for each, for a mean interrater correlation of $r = 0.91$. With the use of the categorical CGAS scores, the two interviewers' CGAS ratings agreed in 40 of 48 cases (83%); the summary reader and the two interviewers agreed in 41 of 48 cases (85%) and in 42 of 48 cases (88%), respectively, a mean categorical agreement of 85%. The consensus CGAS score, rather than an individual rater CGAS score, was used to calculate the sensitivity and specificity of the PSC.

Overall agreement between clinician consensus CGAS and PSC classification was 79% (chi square = 16.47;

Table III. Relationship between PSC and other screening measures*

	PSC score		χ^2	P
	<28	28+		
Any psychotherapeutic Rx				
Never had Rx	18 (90.0)	11 (39.3)	11.17	0.001
Had some Rx	2 (10.0)	17 (60.7)		
CGAS consensus				
Functional	19 (95.0)	9 (32.1)	16.47	0.0001
Dysfunctional	1 (5.0)	19 (67.9)		
DSM-III Dx (-phobia, enuresis)				
No diagnosis	16 (80.0)	2 (7.1)	23.41	0.0001
Has diagnosis	4 (20.0)	26 (92.9)		
MD rating of child				
Functional	16 (94.1)	12 (52.2)	6.31	0.012
Dysfunctional	1 (5.9)	11 (47.8)		
High stress				
Not high stress	18 (90.0)	18 (66.7)	2.31	0.129
Has high stress	2 (10.0)	9 (33.3)		

Rx, treatment.

*Values in parentheses are percentages.

$P < 0.0001$) (Table III). Nineteen of the 20 subjects classified as dysfunctional by the clinicians were correctly identified by the PSC, a sensitivity of 0.95. The PSC correctly classified 19 of the 28 children who were functioning adequately (who had been given negative CGAS consensus ratings by the interviewers), a specificity of 0.68. The overall correlation between specific consensus CGAS ratings and PSC scores was $r = 0.69$.

A Receiver Operating Characteristic curve (Figure) was used to plot specificity versus sensitivity over the range of possible cutoff scores.²¹ The ROC curve depicts the impact of changing the cutoff point, and the inserted box gives the sensitivity and specificity for different cutoff score values and the percentage of this sample that would have been selected for each of the various cutoff points between 21 and 36.

Although nine "well" children had positive PSC scores, examination revealed that the CGAS scores of seven of these nine children were within 3 points of being considered functional by the mental health clinicians had found

that coding distinctions of ± 3 points on the CGAS were the smallest that could be justified on clinical or statistical grounds, the functional unit of measurement on the CGAS was actually 3 CGAS points. Thus seven of the children who appeared to have "false positive" results on the PSC were actually rated as being just one coding unit away from being considered dysfunctional by the clinicians. Therefore these seven children can be viewed as having only marginally adequate functioning.

Of the other two children classified by the PSC as dysfunctional, one had a PSC score exactly at the cutoff point, and both of these children were living in stressful circumstances, which may have significantly added to their PSC scores. One child had lost an uncle and a cousin by murder within the previous few months; the other's father had been arrested and incarcerated for criminal activities earlier in the year. Although the clinicians thought that these children were functioning adequately overall, both had a number of psychosomatic and behavioral symptoms that may have led their mothers to give higher scores when they initially filled out the PSC.

The final PSC-versus-consensus disagreement was for the child who was rated as dysfunctional by the clinicians but not by the PSC. Although this 6-year-old boy was highly symptomatic, he was functioning within age expectations in many ways, and his mother may have given him "the benefit of the doubt" while filling out the form. One of the interviewers originally rated this subject as functioning adequately before going along with the consensus rating.

Structured psychiatric interview: DICA-P. In this sample of young children, the diagnoses of simple phobia and mild enuresis were prevalent but were considered nonindicative of serious psychiatric impairment. The number of other DSM-III diagnoses for each subject was summed, and subjects were categorized as to whether they did or did not have a psychiatric diagnosis. Ninety-three percent of the subjects with positive PSC scores were found to have a psychiatric diagnosis, in contrast with only 20% of the PSC-negative subjects ($\chi^2 = 23.41$; $P = 0.0001$), giving the PSC a sensitivity of 0.87 and a specificity of 0.89, if the presence of a serious psychiatric diagnosis is used as the measure of "true disorder."

Pediatrician ratings of children's functioning. Pediatrician rating forms were returned for 40 (83%) of the 48 children in the interview sample. Thirty-eight of the 40 children were considered to be known to the pediatrician. The mean rating for children scored as functional by the PSC was 2.0, and the mean rating for children with positive PSC scores was 3.3 ($t = 4.15$; $P < 0.001$). Thirty percent of the children were rated as having serious (4) or very serious (5) problems for which they needed referral. With the pediatrician ratings used to assess convergent

validity, the children all dysfunction the instrument considered likely, the PSC further evaluations and associated (chi

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DISCUSS

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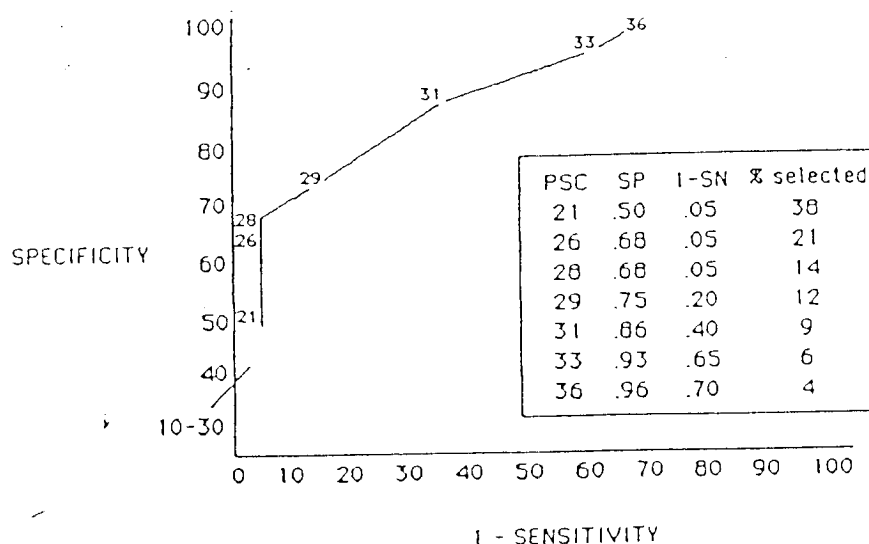


Figure PSC ROC curve: screening accuracy of various cutoff scores. SP, specificity; SN, sensitivity.

validity, the PSC "correctly" classified 11 of the 12 children already considered by the pediatrician to be dysfunctional, a further demonstration of the sensitivity of the instrument. Conversely, however, of the 28 children considered by the pediatricians to be functioning adequately, the PSC screened 12 as positive and thus as needing further evaluation. Despite these differences, physician ratings and PSC screenings scores were significantly associated (chi square = 6.31; $P < 0.05$).

Life Events Scale. The LES scores fell between 0 and 233, with a mean of 76. Eleven of the 28 children identified as dysfunctional by the PSC had LES scores above the median; only two of the 20 children identified by the PSC as functional scored in this range. The mean stress score of the children with positive PSC scores was 96.14, and that of the children PSC with negative scores was 48.95 ($t = 3.08$; $P = 0.002$).

In the categorical analyses, of the 11 children who received total stress scores above the cutoff point, nine had PSC scores of 28 or greater (chi square = 2.3; $P = 0.13$). Thus the majority of children who had experienced very high stress levels were coded as dysfunctional by the PSC, but the reverse was not true; only about one third (9/28) of the children coded as dysfunctional by the PSC had experienced exceptionally high degrees of stress. This is precisely the relationship that would have been predicted for a screening measure such as the PSC.

DISCUSSION

The central questions for any screening measure are validity and practicality. As we tried to define the most certain measure for validating the PSC, we confronted a

number of difficult choices. Although we did use a structured psychiatric interview (DICA-P), this method's emphasis on cataloging symptoms and the resulting high percentage of children given one or more psychiatric diagnoses²⁴ was not congruent with most pediatricians' approach, which emphasizes developmental expectations, daily functioning, and, given the pace of the office practice, a lower percentage of children needing further evaluation. Other questionnaires measuring level of stress or use of psychologic services are helpful but not sufficiently specific to provide definitive validation of a screening procedure. Comparing a screening procedure to pediatricians' ratings of their own patients' psychosocial functioning is a useful approach to validation; however, pediatricians underdiagnose psychosocial disorders,²⁵⁻²⁷ and thus, although relevant, their ratings are not adequate as a sole standard. Although we used all of the above-mentioned approaches, ultimately we chose a somewhat innovative "gold standard." We thought that a psychosocial screening instrument should indicate to the pediatrician a child's general overall psychosocial functioning. The PSC should reflect how the school-age child is currently meeting age-appropriate goals in school, play, peer relationships, family life, and the quality of the child's mood. Because there were preliminary data that the PSC had a high sensitivity, and because this was the first PSC validation study using in-depth interviews, we decided to sample more children screened positive (28 of the 48 interviewed).

All of the measures indicated that the PSC is an acceptably valid screening questionnaire for school-age children in the context of a pediatric office visit. The sensitivity of 0.95 when CGAS is used as the validity

standard suggests that children scoring below the cutoff point are unlikely to have significant psychosocial dysfunction. Although a 5% false positive rate is not ideal, it is an acceptably low figure when a screening instrument is used for any but the most severe disorders. The specificity of 0.68 indicates that if the PSC cutoff score of 28 is used, 68% of children identified are truly dysfunctional and 32% would have false positive results. The rate of false positive results reflects the real difficulty in judging when a child has become sufficiently dysfunctional to warrant further pediatric assessment (a matter that could be the cause of legitimate disagreement between any two pediatricians). In reference to the ROC curve (Figure), a pediatrician could decide to change the cutoff score and achieve a higher specificity (fewer false positive results), for example, by using a PSC score of 31. In this case, 86% of the children screened would be truly dysfunctional and the false positive rate would be only 14%. However, the statistical "cost" of this higher cutoff point is that there would be more false negative results—some children in need of further attention would be missed—as the sensitivity drops from 0.95 to 0.60.

A child scoring positive on the PSC was more likely to have a serious psychiatric diagnosis, to have experienced more stress, and to have been in psychiatric treatment. The pediatricians participating in the study thought that approximately half of the children rated as dysfunctional did not need further attention. We cite just two examples: One child with a positive PSC score who was rated as not needing further evaluation by his pediatrician had experienced the suicide of his mother and was stealing, aggressive, and depressed. Another child was having major academic difficulties in school and also had poor peer relationships.

What implications do these findings have for a pediatrician in a busy, largely middle-class practice? We can make some informed estimates. If a pediatrician saw 50 school-age children a week, approximately 48 parents would complete the PSC while in the waiting room. The receptionist would score the questionnaire and attach it to the chart, with the entire process taking 3 to 5 minutes. Of the 48 children screened, the PSC would classify 14%, or approximately seven children, as needing further evaluation. Of the seven, probably three would already be known to the pediatrician. The four children previously not known to be in distress or dysfunctional could then be assessed further by a brief pediatric interview, which the pediatrician could start by looking at the PSC and asking about the most problematic behaviors and then going on to review the major areas of the child's psychosocial functioning.²⁴ Of the four newly discovered children with positive PSC screening scores, one would have minimal difficulties

and three would have a level of dysfunction previously underestimated or unknown by the pediatrician. On the basis of a brief office interview, the pediatrician could decide to follow these children more closely or to refer them, as indicated, for a more comprehensive assessment. In our hypothetical week, four brief interviews would add a total of 1 hour to the pediatrician's practice time, but there would probably be some saving of time in not having to review the psychosocial functioning of the 41 children who scored below the screening point. Given the sensitivity of 0.95, two of the 41 children defined by the PSC as functioning well would have false negative results; these children would be truly dysfunctional but not identified.

Many questions remain. Would the PSC, if used in office practice, change the pediatrician's behavior either by focusing efforts on the children screened as dysfunctional or by increasing the referral rate for mental health services above the current level of only 1% or 2%? Would having patients screened and identified encourage pediatricians to improve their psychosocial interviewing and evaluation skills?²⁵ What is the natural history of children identified by the PSC, and would pediatric attention or referral be helpful? Would parents actually accept this more direct approach to assessing psychosocial functioning, and would consistent efforts in this direction encourage parents to ask more questions? Would parents pay for the pediatrician's time spent on further evaluation and, if indicated, accept a referral? Are appropriate mental health services readily available and affordable?

Our study suggests that the PSC is a practical method of screening psychosocial disorders in pediatric outpatient practice.

We thank Drs. Leon Eisenberg, Philip Lavori, Barbara Burns, and Lionel Hersov and Mrs. Helen Kiddy for their advice and support.

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Use of the Pediatric Symptom Checklist to Screen for Psychosocial Problems in Pediatric Primary Care

A National Feasibility Study

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Diane M. Comer, BA; Kelly J. Kelleher, MD, MPH

Background: Routine use of a brief psychosocial screening instrument has been proposed as a means of improving recognition, management, and referral of children's psychosocial morbidity in primary care.

Objective: To assess the feasibility of routine psychosocial screening using the Pediatric Symptom Checklist (PSC) in pediatrics by using a brief version of the checklist in a large sample representative of the full range of pediatric practice settings in the United States and Canada. We evaluated large-scale screening and the performance of the PSC in detecting psychosocial problems by (1) determining whether the prevalence of psychosocial dysfunction identified by the PSC was consistent with findings in previous, smaller samples; (2) assessing whether the prevalence of positive PSC screening scores varied by population subgroups; and (3) determining whether the PSC was completed by a significant proportion of parents from all subgroups and settings.

Patients and Methods: Twenty-one thousand sixty-five children between the ages of 4 and 15 years were seen in 2 large primary care networks: the Ambulatory Sentinel Practice Network and the Pediatric Research in Office Settings network, involving 395 pediatric and family practice clinicians in 44 states, Puerto Rico, and 4 Canadian provinces. Parents were asked to complete a brief questionnaire that included demographic information, history of mental health services, the 35-item PSC, and the number of pediatric visits within the past 6 months.

Results: The overall prevalence rates of psychosocial dysfunction as measured by the PSC in school-aged and preschool-aged pediatric outpatients (13% and 10%, respectively) were nearly identical to the rates that had been reported in several smaller samples (12%-14% among school-aged children and 7%-14% among preschoolers). Consistent with previous findings, children from low-income families were twice as likely to be scored as dysfunctional on the PSC than were children from higher-income families. Similarly, children from single-parent as opposed to those from 2-parent families and children with a past history of mental health services showed an elevated risk of psychosocial impairment. The current study was the first to demonstrate a 50% increase in risk of impairment for male children. The overall rate of completed forms was 97%, well within an acceptable range, and at least 94% of the parents in each sociodemographic subgroup completed the PSC form.

Conclusions: Use of the PSC offers an approach to the recognition of psychosocial dysfunction that is sufficiently consistent across groups and locales to become part of comprehensive pediatric care in virtually all outpatient settings. In addition to its clinical utility, the consistency and widespread acceptability of the PSC make it well suited for the next generation of pediatric mental health services research, which can address whether earlier recognition of and intervention for psychosocial problems in pediatrics will lead to cost-effective outcomes.

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Editor's Note: I get depressed every time I'm reminded that more than 1 in every 10 children suffer from a psychosocial problem

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CHILDHOOD psychosocial dysfunction, considered a "new morbidity" 20 years ago, has become widely acknowledged as the most common chronic condition of children and adolescents.^{1,2} Epidemiological studies report that 14% to 20% of all school-aged US

children and 13% of preschoolers have an emotional and/or behavioral disorder.^{1,6} The rates of psychosocial impairment seem to be higher in risk groups such as low-income, single-parent households.

Pediatricians have long been an important first resource for parents who are worried about their children's behavioral problems.⁷ With the advent of managed and especially capitated health systems,¹⁰ primary care providers assume an even greater "gatekeeping" responsibility to identify, manage, and refer children with emotional and/or behavioral disorders.¹¹ Yet, recent studies estimate that only about

PARTICIPANTS AND METHODS

SITE AND SAMPLE

The study was conducted in 2 large practice-based primary care research networks: the Pediatric Research in Office Settings (PROS) network¹¹ and the Ambulatory Sentinel Practice Network (ASPN).¹¹ The PROS is a pediatric network that was established in 1986 and currently comprises more than 1300 clinicians from more than 475 practices in all 50 states and the Commonwealth of Puerto Rico. The ASPN is a family medicine network that was established in 1978 and currently consists of 125 practices, with about 750 clinicians from 38 states and 6 Canadian provinces. Eighty-nine percent of PROS clinicians are pediatricians, 10% are nurse practitioners, and 1% are physician assistants. Eighty-five percent of ASPN clinicians are family physicians, 7% are nurse practitioners, and 8% are physician assistants. The ASPN also collaborated with 2 regional networks to expand the number of participating family physicians. The characteristics of the Wisconsin Research Network and the Minnesota Academy of Family Physicians Research Network are similar to those of ASPN and contributed 38 and 24 participating clinicians, respectively.

Clinicians who had previously completed PROS or ASPN research studies and were not participating in other major studies were recruited by network coordinators and staff. After agreeing to participate, all clinicians completed the practice questionnaire assessing practice structure, attitudes, and training related to psychosocial problems. After completion of the practice questionnaire, practices received training materials for the study including a videotape and written instructions.

Three hundred ninety-five pediatric and family practice clinicians in 44 states, Puerto Rico, and 4 Canadian provinces participated in data collection for the Child Behavior Study (principal investigator, K.J.K.). Prior research from both ASPN and PROS confirms the comparability of patients, clinicians, and practices participating in primary care networks studies with those identified in national samples.³⁴⁻³⁷ A survey conducted as part of the Child Behavior Study³⁸ showed no difference in demographic factors, practice characteristics, or attitudes toward psycho-

social problems among participating pediatricians and a random sample of primary care pediatricians from the American Academy of Pediatrics. Pediatricians from the American Academy of Pediatrics, however, had minimally higher rates of patients with either private insurance or no insurance.

All children between the ages of 4 and 15 years and their parents or guardians who visited the clinician's office for health care during the practice's enrollment period were approached in the waiting room for written consent to participate in the study. Procedures and consent forms were approved by institutional review boards affiliated with PROS, ASPN, and the University of Pittsburgh, Pittsburgh, Pa. Each clinician enrolled a consecutive sample of about 60 children aged 4 to 15 years presenting for non-emergent visits in the presence of a parent or caregiver.

All study materials were mailed to the research networks for inspection, verification, and coding. Data entry was contracted out to an independent organization.

MEASURES

Sociodemographic Variables

Data on each child's age, sex, racial/ethnic background, health status, history of own and parental use of mental health services, parental marital status, parental education, and use of Medicaid insurance were recorded on the clinician visit questionnaire. The highest level of education for either parent was used as an estimate of SES. Parents with a high school education or less were coded as low SES; parents with some college, a college degree, or a technical school degree were coded as middle SES; and parents with a graduate or professional degree were coded as high SES.

Psychosocial Functioning

Psychosocial functioning was assessed using the PSC (**Figure**). The PSC consists of 35 items that are rated as never, sometimes, or often present (scored 0, 1, and 2, respectively). Item scores are summed and the total score is recoded into a dichotomous variable indicating psychosocial impairment. For children aged 6 through 16 years, the cutoff score is 28 or higher. For 4- and 5-year-old children, the PSC cutoff is 24 or higher.^{20,39}

50% of these children are identified by their primary care physicians and that, once identified, only a fraction of them receive appropriate mental health treatment.^{9,12,13}

Despite the growing burden of psychosocial morbidity, pediatricians do not receive adequate training concerning psychosocial problems, are hesitant to attach potentially deleterious labels to children,¹¹ do not have time during office visits to address psychosocial needs, and may have limited access to mental health referral networks.¹³ Recent efforts such as the American Board of Pediatrics increasing ambulatory and behavioral training requirements² and publications such as *Bright Futures*¹⁶ and the *Diagnostic and Statistical Manual for Primary Care*¹⁷ may help to increase awareness of psychosocial morbidity over the long term, but now primary care pediatricians still

struggle to provide psychosocial services.^{2,16,17} Given the focus on productivity and profitability, the move to managed care approaches in medicine has created additional pressure for pediatric clinicians to limit attention on psychosocial problems.

One approach to facilitating recognition and referral of psychosocial problems is to use a parent-completed screening questionnaire as part of routine primary care visits.¹⁸ The Pediatric Symptom Checklist (PSC) was developed for this purpose. The PSC is a 1-page questionnaire of children's emotional and behavioral problems that reflects parents' impressions of their children's psychosocial functioning. Cutoff scores for school-aged and pre-school-aged children indicating clinical levels of dysfunction have been empirically derived using receiver operator characteristic analyses in studies comparing the

Please mark under the heading that best fits your child

	Never	Sometimes	Often
1. Complains of aches or pains	_____	_____	_____
2. Spends more time alone	_____	_____	_____
3. Tires easily, little energy	_____	_____	_____
4. Fidgety, unable to sit still	_____	_____	_____
5. Has trouble with a teacher	_____	_____	_____
6. Less interested in school	_____	_____	_____
7. Acts as if driven by a motor	_____	_____	_____
8. Daydreams too much	_____	_____	_____
9. Distracted easily	_____	_____	_____
10. Is afraid of new situations	_____	_____	_____
11. Feels sad, unhappy	_____	_____	_____
12. Is irritable, angry	_____	_____	_____
13. Feels hopeless	_____	_____	_____
14. Has trouble concentrating	_____	_____	_____
15. Less interest in friends	_____	_____	_____
16. Fights with other children	_____	_____	_____
17. Absent from school	_____	_____	_____
18. School grades dropping	_____	_____	_____
19. Is down on himself or herself	_____	_____	_____
20. Visits doctor, with doctor finding nothing wrong	_____	_____	_____
21. Has trouble sleeping	_____	_____	_____
22. Worries a lot	_____	_____	_____
23. Wants to be with you more than before	_____	_____	_____
24. Feels he or she is bad	_____	_____	_____
25. Takes unnecessary risks	_____	_____	_____
26. Gets hurt frequently	_____	_____	_____
27. Seems to be having less fun	_____	_____	_____
28. Acts younger than children his or her age	_____	_____	_____
29. Does not listen to rules	_____	_____	_____
30. Does not show feelings	_____	_____	_____
31. Does not understand other people's feelings	_____	_____	_____
32. Teases others	_____	_____	_____
33. Blames others for his or her troubles	_____	_____	_____
34. Takes things that do not belong to him or her	_____	_____	_____
35. Refuses to share	_____	_____	_____

Pediatric Symptom Checklist.

performance of the PSC with other validated questionnaires and clinicians' assessments of children's overall functioning.^{19,20} In validity studies, PSC case classifications agreed with case classifications on the Children's Behavior Checklist (CBCL), clinicians' Global Assessment Scale ratings of impairment, and the presence of psychiatric disorder in a variety of pediatric and subspecialty settings representing diverse socioeconomic backgrounds.^{19,25} When compared with the Children's Global Assessment Scale scores in both middle- and lower-income samples, the PSC has shown high rates of overall agreement (79% and 92%), sensitivity (95% and 88%), and specificity (68% and 100%).^{21,22} Studies using the PSC have found prevalence rates of psychosocial impairment in middle-class or general settings that are quite comparable to national estimates of psychosocial problems.^{19,25} More recently, efforts are under way to develop specific subscales of the PSC for use in identification of attentional, internalizing (depression/anxiety), and behavior problems (W. Gardner, MD, unpublished data, 1998).

Previous studies using a variety of measures have consistently shown that the prevalence of psychosocial impairment varies considerably based on several socio-demographic risk factors, and research with the PSC has paralleled many of these findings. For example, low socioeconomic status (SES),²⁶ living with a single parent,²⁷ parental mental illness,²⁸ family discord,²⁹ the child's temperamental characteristics, and male sex^{30,31} have all been shown to increase the probability of psychosocial dysfunction. Consistent with these findings, studies using the PSC have shown the prevalence of child psychosocial dysfunction to be 2 to 3 times higher in children with low family incomes, single parents,²² or mentally ill parents.²³

Some investigators have recommended that the PSC should be considered "basic office equipment" in pediatrics¹⁸ and others have argued that the PSC should become a mandated part of all well-child visits in managed care settings or large programs like Medicaid Early Periodic Screening Diagnosis and Testing.²⁴ Routine use of a brief screening instrument like the PSC could provide a counterbalance to the previously mentioned pressures toward underrecognition, but such recommendations presuppose that the use of the PSC would be feasible across the full range of practice settings among diverse populations and regions.

Previous studies have shown that the PSC is a feasible method of early detection in selected pediatric sites, but these findings have been limited to samples of less than 500 patients. Sample sizes have been too small to investigate systematically the feasibility of using the PSC to screen for dysfunction in diverse types of pediatric practices that use varying methods of insurance reimbursement, are located in a variety of geographic regions in the United States, and that include family practice clinicians.

Our study assessed the feasibility of routine psychosocial screening with the PSC in a large national sample involving more than 21 000 pediatric outpatients drawn from the practices of 395 primary care clinicians representing 44 states, Puerto Rico, and 4 Canadian provinces. Specifically, the assessment of the PSC's feasibility was operationalized by examining whether (1) in the current sample the overall prevalence of positive PSC screening scores was consistent with previously reported findings; (2) the prevalence of positive PSC screening scores varied by sociodemographic subgroups as in previous studies; and (3) the use of the PSC was feasible for use with the full range of parents as evidenced by high and comparable rates of questionnaire completion across groups.

RESULTS

SAMPLE

Twenty-two thousand fifty-nine preschool-aged and school-aged children met the initial criteria for inclusion and were enrolled in the study. No differences in age or sex were detected in a comparison of participating children with non-participating children. Children in the western United States were slightly more likely to participate. Of participating

Table 1. Sociodemographics, Health Status, and Use of Mental Health Services of Preschoolers, School-aged Children and Adolescents, and the Total Sample*

	Total Sample, Aged 4-15 y (N = 21 065)	Preschoolers, Aged 4-5 y (n = 5573 [26% of Total])	School-aged Children and Adolescents, Aged 6-15 y (n = 15 492 [74% of Total])
Sex			
M	10 477 (50)	2760 (50)	7717 (50)
F	10 588 (50)	2813 (50)	7775 (50)
Parent education			
Low	4845 (23)	1336 (24)	3509 (23)
Middle	11 677 (55)	3107 (56)	8570 (55)
High	4543 (22)	1130 (20)	3413 (22)
Race			
White	17 346 (82)	4466 (80)	12 880 (83)
African American	1356 (6)	442 (8)	914 (6)
Hispanic	1648 (8)	474 (8)	1174 (8)
Asian American	397 (2)	104 (2)	293 (2)
Native Alaskan	146 (0.7)	34 (0.6)	112 (0.7)
Other	172 (0.8)	53 (1)	119 (0.8)
Minority status	3719 (18)	1107 (20)	2612 (17)
Parental marital status			
2 Parents living together	15 073 (72)	4099 (74)	10 974 (71)
Single parent	5992 (28)	1474 (26)	4518 (29)
Health status			
Good or very good	20 265 (96)	5381 (97)	14 884 (96)
Fair or poor	800 (4)	192 (3)	608 (4)
Ever received mental health services	3758 (18)	432 (8)	3326 (22)
Medicaid insurance	3749 (18)	1191 (21)	2558 (17)

*Data are presented as number (percentage).

children, 665 (3%) had PSCs that were missing 5 or more items and 339 (1.5%) had other missing data, leaving a final sample of 21 065 children.

As shown in **Table 1**, of the final sample of children, 5573 (14%) were of preschool age, 10 477 (50%) were male, 3719 (18%) were from minority backgrounds, and 5992 (28%) were from single-parent households (separated, divorced, or deceased spouse). Of the total sample, 4543 children (22%) had at least 1 parent with a graduate or professional degree; 11 677 (55%) had at least 1 parent with some college, a college degree, or a technical school degree, and 4845 (23%) had parents with a high school diploma or less. Three thousand seven hundred forty-nine (18%) were covered by Medicaid insurance. Eight hundred children (4%) were reported by their parents to have fair or poor health. Three thousand seven hundred fifty-eight (18%) had a history of using mental health services.

PSYCHOSOCIAL FUNCTIONING AND RISK FACTOR GROUPS

As presented in **Table 2**, the PSC identified 2077 (13%) of the school-aged children as having psychosocial dysfunction, a prevalence rate that is consistent with the rates of 12% to 14% found in previous PSC studies in middle- or mixed-income samples. Among preschoolers, the prevalence of psychosocial dysfunction was 10% (580/5573), the mean of previous reported prevalence rates (7% and 14%) in 2 small samples that used the PSC with 4- and 5-year-olds.^{19,21} Analysis of PSC case rates by region showed that the rate of psychosocial dysfunction was

10% in the northeastern practices, 13% in southern and western practices, 15% in midwestern practices, and 16% in Canadian practices ($P < .001$). Table 2 also presents the results of previous studies of the PSC in pediatric outpatient settings^{19,21-24} in comparison with those of the current study.

As in previous studies, rates of psychosocial dysfunction were about 2 times higher for low SES children (parents have a high school education or less) than for high SES children (at least 1 parent has a graduate or professional degree) both for school-aged children (20% vs 9%) and for preschoolers (15% vs 6%). Results were almost as consistent with regard to the risk factor of coming from a single-parent family. In all previous studies with the PSC, children from single-parent families were more likely to be coded as dysfunctional than children from 2-parent families, although the increase in risk ranged from 10% to 5-fold. In the current study, for both school-aged and preschool-aged children, the increase in risk was just more than double (22% vs 10% and 17% vs 8%, respectively).

As indicated in **Table 3**, both poverty and single-parent status were significantly associated with higher mean PSC scores. The mean PSC score of children from single-parent households was 4 points higher (18.1 [SD = 11.3]) than the mean PSC score of children from 2-parent families (13.9 [SD = 9.2], $t = -25.8$, $df = 9315.8$, $P < .001$). Low-income children also averaged 4 points higher on the PSC (17.2 [SD = 11.2]) compared with children of middle- (13.2 [SD = 9.0]) or higher-income status (14.9 [SD = 9.7], $F = 195.66$, $df = 221.062$, $P < .001$).

Table 2. Prevalence of Psychosocial Dysfunction in Children Aged 4 to 16 Years in Medical Outpatient Settings*

	Jellinek et al. ¹⁸ (N = 206)	Jellinek et al. ¹⁹ (N = 300)	Murphy et al. ²⁰ (N = 123)	Rauch et al. ²¹ (N = 377)	Murphy et al. ²² (N = 379)	Pagano et al. ²³ (N = 1117)	Little et al. ²⁴ (N = 115)	Kelleher et al., 1996 (N = 15 492)	Kelleher et al., 1996 (N = 5573)
Setting	Suburban practice	Suburban/ urban HMO	Dermatology health center	Public health practices	Public health clinic	Suburban clinic	Outpatient practice	Network practices	Network practices
Age range, y	6-12	6-12	6-12	6-12	6-12	4-5	4-5	6-15	4-5
PSC case rate	12 (25/206)	14 (43/300)	22 (27/123)	13 (48/377)	11 (40/379)	7 (8/117)	14 (16/115)	13 (2077/15 492)	10 (580/5573)
Socioeconomic status									
Low	19 (4/21)	...	22 (11/50)	19 (16/83)	...	...	27 (3/11)	20 (715/3509)†	15 (203/1336)†
Lower/middle	8 (4/48)	24 (10/42)†	25 (9/36)	9 (14/152)	...	...	20 (4/20)	13 (1072/8570)	10 (305/3107)
Upper/middle	8 (7/90)	13 (38/258)	10 (1/10)	5 (4/78)	...	...	13 (8/61)	9 (290/3413)	6 (72/1130)
Parental marital status									
Single parent	...	18 (14/76)	34 (26/77)	...	18 (14/76)§	10 (2/20)	...	22 (1004/4518)†	17 (249/1474)†
Parents living together	...	13 (11/29)	7 (3/46)	...	8 (26/307)	8 (5/72)	...	10 (1073/10 974)	8 (426/5141)
History of therapy									
History	...	89 (17/19)†	100 (2/2)	26 (8/31)	29 (5/21)†	0 (3/1)	...	37 (1223/3226)†	36 (154/432)†
No history	...	38 (11/29)	55 (12/22)	12 (40/346)	9 (34/362)	8 (8/104)	...	7 (854/12 166)	8 (426/5141)
Sex									
M	15 (17/111)	17 (25/149)	31 (16/52)	15	10 (21/203)	12 (7/60)§	9 (5/53)	17 (1347/7717)†	12 (333/2760)†
F	8 (8/95)	13 (18/140)	16 (11/71)	11	11 (19/176)	2 (1/57)	18 (11/62)	9 (730/7775)	9 (247/2813)

*All studies used the Pediatric Symptom Checklist (PSC). Data are presented as percentage (number/total number). Ellipses indicate not applicable; HMO, health maintenance organization.

† $P < .001$.

‡ $P < .01$.

§ $P < .05$.

Table 3. Comparison of Mean Pediatric Symptom Checklist Scores Within Selected Risk Factor Groups

	No. of Patients	Mean (SD) [Range]
Total sample	21 065	15.1 (10.0) [0-65]
Sex		
M	10 477	16.6 (10.5) [0-63]*
F	10 588	13.5 (9.3) [0-65]
Age/sex		
Preschool boys	2760	14.5 (8.0) [0-48]*
Preschool girls	2813	12.8 (7.7) [0-51]
School-aged boys	7717	17.3 (11.2) [0-63]*
School-aged girls	7775	13.8 (9.8) [0-65]
Parental education		
Low	4845	17.2 (11.2) [0-65]*
Middle	11 677	14.9 (9.7) [0-64]
High	4543	13.2 (9.0) [0-54]
Parental marital status		
Parents living together	15 073	13.9 (9.2) [0-64]*
Single parent	5992	18.1 (11.3) [0-65]

* $P < .001$.

Previous research had demonstrated consistent significant associations between a history of mental health treatment and higher scores on the PSC. The current study not only confirmed this finding for school-aged children, but suggested that it was even stronger than had previously been reported, with a 4- to 5-fold increase in risk rather than the 2- to 3-fold increase that had been noted in the smaller previous studies (37% vs 7%). Similarly, for preschoolers, a history of mental health services nearly quadrupled the likelihood of psychosocial impairment as measured by the PSC (36% vs 8%).

Although previous studies had shown mixed results in terms of sex differences, the current study demonstrated that boys were significantly more likely to have higher PSC scores than girls for both school-aged (17% vs 9%) and preschool-aged children (12% vs 9%). As indicated in Table 3, the mean PSC score of school-aged boys was more than 3 points higher than the mean PSC score of school-aged girls (17.3 [SD = 11.2] compared with 13.8 [SD = 9.8], respectively). The difference between boys and girls seemed to be somewhat less pronounced in the preschool years, where the mean PSC score for boys was about 1½ points higher than the mean for girls (14.5 [SD = 8.0] compared with 12.8 [SD = 7.7]; $t = -8.0$, $df = 5571.0$, $P < .001$).

PARENTS' COMPLETION OF THE PSC

The feasibility of using the PSC was assessed by comparing the percentage of forms that were returned with at least 30 of the 35 items completed (no more than 5 missing items) across sociodemographic and risk groups. The overall rate of completed forms was well within an acceptable range for all groups assessed, with at least 94% of the parents in each group fully completing the PSC form (missing data on no more than 5% of the forms). In the sample as a whole, 97% of children screened had completed PSCs. No significant differences in completion rates were found by medical specialty (either family or pediatric practice), geographic region, or managed vs non-managed care plan membership. Parents' completion rates were slightly lower in urban locales (95% vs 98% [rural] and 98% [suburban], $P < .001$), for low SES parents (95% vs 98% [middle SES parents] and 98% [high SES parents], $P < .001$), among those parents receiving Medicaid (94% vs 98% of those not receiving Med-

icaid; $P < .001$), and among minority parents (94% vs 98% among non-minority parents; $P < .001$).

COMMENT

Parents of more than 21 000 children aged 4 to 15 years seen in 2 large primary care networks involving 395 primary care clinicians in 44 states, Puerto Rico, and 4 Canadian provinces voluntarily filled out the PSC. Unlike previous studies using the PSC, screening was successfully implemented by clinic personnel without the aid of research assistants or other personnel trained specifically for study purposes. Ninety-seven percent of participating parents completed the PSC. The successful implementation of psychosocial screening using already existing personnel and the high rate of screening completion indicates that the PSC offered a feasible method of screening 4- to 15-year-old children attending both pediatric and family medicine practices nationwide.

The prevalence of psychosocial dysfunction in school-aged children in this nationally representative sample was 13%, a rate that is virtually identical to rates of impairment reported in previous studies using the PSC in outpatient mixed SES samples.¹⁹ The rate of impairment among preschool-aged children (10%) was also comparable to rates in previous studies of smaller samples. There has been some variability in the prevalence of preschool psychosocial dysfunction as measured by the PSC.^{20,29} A recent study of a low-income, predominantly Mexican American population³⁹ showed a rate of 7% among 4- and 5-year-olds, compared with 14% among a suburban, predominantly middle-income sample and 11% in the current sample. This variability may be accounted for by several factors. The lower prevalence rate found in the small sample of Mexican American preschoolers may have been a result of underreporting by a population of parents whose native language and cultural expectations were different. Previous PSC studies of preschoolers have used very small samples of about 100 subjects, which may have contributed to artificially high or low prevalence rates. In accordance with previous studies using the PSC, poverty and coming from a single-parent family doubled the risk of psychosocial dysfunction. Children with a history of mental health treatment were 4 to 5 times more likely to have high PSC scores.

This was the first study of the PSC with school-aged children to document the significantly higher rate of dysfunction for boys, a finding that was also significant for preschoolers. In both age groups, boys were about 1½ times more likely to be coded as cases on the PSC. These results are consistent with epidemiological findings showing a higher prevalence of parent-identified behavioral problems and a higher rate of mental health referral in male children and adolescents than in female children and adolescents.⁷ Previous studies also suggest that girls are more likely than boys to have internalizing difficulties (ie, anxiety and depression), which may not be as readily identified and/or reported by parents or teachers.⁷

The PSC has performed as predicted in 8 published primary care studies including the current sample of more than 21 000 children. Results of these studies have consistently demonstrated that about 1 of every 8 children

seen in primary care have significant levels of psychosocial problems.

Given the high rates of unrecognized, untreated psychosocial problems in children, the PSC could play an important role in comprehensive care and health supervision. If the PSC scores are high, the physician may spend a few minutes with the parents going over the items they checked off to affirm validity and assess severity. This information may help the physician facilitate a discussion of the child's major areas of functioning (family, school, activities, and mood states), notable stressors (maternal depression or parental discord), and risk factors. The physician may then determine the need for pediatric follow-up to reassess impairment, parental guidance, or mental health referral.

Facing a rising prevalence of emotional and behavioral problems and limitations on reimbursement within the managed health care system, pediatricians may wish to screen and spend available time on those children with serious impairment. While the PSC offers an approach to identifying the growing number of children with psychosocial dysfunction, trials of screening and intervention will be necessary to assure improved outcomes for children with emotional and behavioral disorders as well as to assess the cost offset of enhanced care.

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Announcement

1999 Certifying Examinations of the American Board of Pediatrics: Adolescent Medicine Subspecialty Examination*

Examination Date: November 15, 1999. Registration for first-time applicants: February 1, 1999, through April 30, 1999 (postmarked). Registration for reregistrants: March 15, 1999, through June 15, 1999 (postmarked).

*If you are applying through the ABIM for the 1999 Adolescent Medicine Certifying Examination, you must contact ABIM for registration dates.

You must contact the ABP for application material. Each application will be considered individually and must be acceptable to the Subboard. The eligibility requirements may be obtained by contacting the American Board of Pediatrics, 111 Silver Cedar Ct, Chapel Hill, NC 27514, telephone: 919-929-0461, fax: 919-929-9255, or through the ABP web site <http://www.abp.org>

American
Academy of
Pediatrics



Policy Statement

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The Pediatrician's Role in Development and Implementation of an Individual Education Plan (IEP) and/or an Individual Family Service Plan (IFSP) (RE9823)

AMERICAN ACADEMY OF PEDIATRICS

Committee on Children With Disabilities

ABSTRACT. The Individual Education Plan and Individual Family Service Plan are legally mandated documents developed by a multidisciplinary team assessment that specifies goals and services for each child eligible for special educational services or early intervention services. Pediatricians need to be knowledgeable of federal, state, and local requirements; establish linkages with early intervention, educational professionals, and parent support groups; and collaborate with the team working with individual children.

ABBREVIATIONS. IDEA, Individuals With Disabilities Education Act; IEP, Individual Education Plan; IFSP, Individual Family Service Plan; OHI, Other Health Impaired.

Special education in each local school district is protected and regulated by strong legislative and judicial safeguards created by the federal Education for All Handicapped Children Act (PL 94-142). This act was reauthorized in the 1991 legislation PL 101-476 under the new title, Individuals With Disabilities Education Act (IDEA), which has four key components: 1) identification of children with learning-related problems; 2) evaluation of the health and developmental status of the child with special needs, determining current and future intervention requirements, and developing a plan to match services to needs; 3) provision of services that include educational and related services; and 4) guaranteed due process.¹ These federally legislated safeguards establish that children with disabilities and their parents share the same legal right to a free and appropriate education as children without disabilities.

Federal legislation requires that each child recognized as having a disability that interferes with learning has a written plan of service: an Individual Education Plan (IEP) for children aged 3 through 21 years, an Individual Family Service Plan (IFSP) for infants and toddlers birth through 3 years, and a Transitional Services Outcome Plan for young adults at 16 years of age. Federal legislation defines transition from school as a coordinated set of activities for a student designed to promote movement from school to postschool activities, including postsecondary education, vocational training, integrated employment, continuing and adult education, adult services, independent living, and community participation. This transition plan highlights and validates the lifelong needs of individuals with disabilities and is the beginning of an integrated program that enables adults with disabilities to live, work, and play in our towns and cities.² The pediatrician is in a key position to participate in planning services and to provide care for these children and young adults.

BACKGROUND

The Individual Education Plan (IEP)

In 1975 Congress enacted PL 94-142, the Education for All Handicapped Children Act, as an

educational bill of rights to assure children with disabilities a free and appropriate education in the least restrictive environment. In 1977 implementation of services was extended to children 3 to 21 years old, although services for children aged 3 to 5 years remained optional. States were also requested to identify children who had not previously received services.

PL 94-142 (currently Part B) allowed children with mental retardation, hearing deficiencies, speech and language impairments, specific learning disabilities, visual impairments, emotional disturbances, orthopedic impairments, and a variety of medical conditions that may interfere with education (categorized as Other Health Impaired [OHI]) to receive special education services. To meet the eligibility criteria, a child's disability must interfere with the educational process and normal school performance to the extent that special education assistance is needed.

Other portions of the law provide the following:

1. Every child must have a multidisciplinary evaluation by a team. This team, working in collaboration with the family, is responsible for designing an IEP that has specific education and therapeutic strategies and objectives. Each plan must be reviewed annually.
2. Every child must be educated in the least restrictive environment. This criterion supports the concept of integrating children with and without disabilities as much as possible and with extra supports and services when necessary to facilitate inclusion.
3. The evaluation team may recommend the following related services: transportation; developmental, corrective, and other supportive services (including speech pathology, audiology, psychological services, and physical and occupational therapy); recreation (including therapeutic recreation); and social work services (including rehabilitative counseling) and medical services (for diagnostic and evaluative purposes only). These services may be required to assist a child to benefit from special education and include early identification and assessment of disabling conditions.³ If the parents approve the IEP, they sign a document and the school is committed to providing these outlined services.
4. The rights of the parents and child to "due process" shall be protected. This ensures the parents' rights to be involved in developing the educational plan and for the meeting to be conducted in their native language or other mode of communication if it is not a written language understandable to the general public. The IEP/IFSP team leader is responsible for arranging and paying for an interpreter if English is not the native language of the home or if the parent has a hearing impairment. Furthermore, parents have the right to appeal when they view the team's decision as inappropriate or harmful.

The Individual Family Service Plan (IFSP)

In 1986 Congress enacted the Education of the Handicapped Act Amendments, PL 99-457.⁴ It was reauthorized in PL 105-17 in 1997. Part C of this reauthorization legislation, formerly known as Part H, called for the creation of statewide, coordinated, multidisciplinary, interagency programs for the provision of early intervention services for all infants and toddlers with disabilities. Although the law did not mandate these services, partial reimbursement of costs was made readily available to states that wished to participate. All states have established programs for children birth to 3 years. These developmental services are designed to meet needs in the areas of physical, cognitive, communicative, and psychological development, and in self-help skills. The purpose of these services is to enhance the development of the infant and toddlers with disabilities; to minimize their potential for developmental delay; and to optimize the abilities of the families to meet the special needs of their children. It was also hoped that this would minimize the cost over time of special education services when youngsters attained school age, decrease the need for institutionalization, and enhance the potential for independent living.

The law requires each state to create its own definition of developmental delay as a basis for determining eligibility for services. Pediatricians played a significant role in determining this eligibility by advocating for a broad definition of developmental delay. Services are provided for children with developmental delay, as well as for those whose biological conditions have a high probability of having a delay. In addition, states have the option to provide services to those children who are at risk of manifesting developmental delays attributable to environmental factors.

A major difference between Part C of PL 105-17 and Part B of PL 94-142 is that Part C focuses on the involvement of the family and supports for the family. Under this law, the evaluation, assessment, and planning take place with family participation and approval. Early intervention services are all optional, subject to family approval, and are provided in natural settings such as the parents' home and child care settings as well as more formal child development programs. The current discussions about early brain development center around children from birth to 3 years. It is during this period that the growth and organization of the brain is most influenced by environmental factors that Part C strives to make optimal.

Children referred as potentially eligible receive a comprehensive multidisciplinary assessment. The assessment describes the abilities and needs of the child and family. Following assessment, an IFSP is created, to include the following:

- the child's present attainments,
- family strengths,
- how to enhance development of the child,
- major outcomes expected, including the outcome measures and criteria, and time lines to achieve specific goals,
- specific early intervention services that the child and family will receive,
- projected dates for initiating services and their duration,
- name of the service coordinator responsible for coordinating and helping the family implement the plan,
- steps to help the child and family with the transition to school services at an appropriate time.

The statute specifies a wide array of other services, but the only health services included are those that are "necessary for the infant or toddler to benefit from other early intervention services." Diagnostic and consultative medical services are also included, but the extent to which these services are funded by the early intervention program varies.

MEDICAL ROLE AND RECOMMENDATIONS

Several roles for the pediatrician exist under IDEA. All pediatricians should ensure that in their practices, every child with a disability has access to the following services:

1. A medical home.^{5,6} A medical home provides care that is accessible, continuous, comprehensive, family-centered, coordinated, and compassionate. For children with special health care needs, many of whom have an IEP or an IFSP, the pediatrician's central role as the provider of primary care means that he or she would participate in the plan development. In

addition, the pediatrician should collaborate with community resources in treatment planning and in promoting early intervention programs that work.

2. Screening, surveillance, and diagnosis.^{7,8} The pediatrician should screen all children from the first encounter, checking for risk or existence of a disability or developmental delay. Pediatricians are in key positions to identify at the earliest possible age those children who may benefit from services under IDEA. Pediatricians should provide screening and surveillance using a combination of methods best designed to take advantage of multiple sources of information.
3. Referral. The pediatrician should be knowledgeable about the referral process to early intervention programs in his or her community and knowledgeable about the parents' right for multidisciplinary team evaluation by the school- or state-designated agency if a disabling condition may be present. In addition, some of the best support of parents comes from other parents who are able to offer emotional and social support and practical advice. Many communities have programs in which parents support each other and help parents new to the system better navigate the system.⁹ Family Voices, a nationwide grassroots network of families and friends speaking on behalf of children with special health care needs, is a creditable organization that can assist parents and pediatricians and is accessible by telephone and the Internet (888/835-5669; www.familyvoices.org).
4. Diagnosis and eligibility. For early intervention, the pediatrician has an important role in the identification of children with established delays and in the diagnosis of conditions with a high probability of developmental delay, which will qualify a child for this program. Each state has developed a definition of these conditions, which should be obtained from the state's lead agency for this infant and toddler program. In addition, some states include "at risk" conditions as defined by the state as eligible for services. Further information about these issues can be obtained from the single point of entry into Part C locally or the state's lead agency. A list of lead agencies for state early intervention services can be obtained from the National Childhood Technical Assistance System (919/962-2001; www.nectas.unc.edu/).
5. Participation in assessment. A child identified through screening or observation as meeting the definition for developmental delay should receive a comprehensive multidisciplinary assessment. The pediatrician has an important role as a referral source or, if more extensive participation is elected, as a member of the multidisciplinary team. Few pediatricians have the flexibility in their schedules to participate in person in lengthy team meetings. Usually, these meetings are scheduled with a short lead time and at the convenience of the educators arranging them. However, all pediatricians should offer to be available by written communication or participate by conference call or other means to offer input to and receive feedback from the assessment team. Ideally, the pediatrician should be a member of the team and attend the IEP/IFSP meeting.
6. Counsel and advice. During the assessment process, families will need a knowledgeable person for medical advice and counsel. Pediatricians can alert parents to the benefits of a pre-IFSP or pre-IEP conference; of their right to sign the IFSP or IEP only when they are comfortable with the recommendations; and their right to have a friend or other advocate at the IFSP and IEP conference. Although a parent may bring their personal attorney to the conference, most parents do not. If an attorney is going to attend on behalf of the family, the family should notify the school agency of that fact before the meeting to give the school an opportunity to have their legal counsel or top administrator scheduled for the conference. The appeal process begins at the district school board where the child resides. The president of the school board and superintendent of schools should receive the written appeal document. If appeal at the district level fails to satisfy the family's concerns, their next appeal is to the State Board of Education. Rarely does an appeal by either the school district or family go to state or federal supreme courts. Each district school board has a published document that advises parents of procedural safeguards, which can be obtained at no cost to the family. Most assessment teams nominate a member as service coordinator to work with the families. A strong link should be developed between the assessment team and the primary care pediatrician, as well as an open sharing of concerns between parents, the pediatrician, and the assessment team.
7. Creation of the IEP and IFSP. Pediatricians who participate in the assessment process should be consulted by the assessment team when these documents are created. Such consultation is

vital to preparing an appropriate and effective plan. The pediatrician should review the plan developed, counsel the family, and comment on health-related issues as needed. The pediatrician should determine if the health-related services proposed are appropriate and sufficiently comprehensive and assist parents in performing their advocacy tasks when there is evidence of inappropriate planning. Ideally, when schools or educational agencies are developing the IEP or IFSP, a pediatrician should serve as a member of the assessment team.

8. Coordinated medical services. When medical services are part of the IEP or IFSP, they should be conducted by the primary care pediatrician or an appropriate pediatric subspecialist. Medical services and communication should be coordinated by the primary care pediatrician or his or her designee in those cases in which the children have complex medical needs involving several physicians or centers. Special education personnel should be made aware of the restrictions of health care insurance including limited referral options and the role of the primary physician as "the gatekeeper" in some programs.
9. Advocacy. Pediatricians have many local and state opportunities to serve as knowledgeable, thoughtful advocates for improved community and educational services for children with disabilities. Pediatricians who select this role need to be aware of the structure of services in the community and the key persons who implement them. Examples of advocacy roles for pediatricians include participation in the local or state early intervention interagency council, consulting with the local school system or state department of education, or becoming a school board member.

CONCLUSION

Participation in interdisciplinary efforts for children with disabilities can help the pediatrician focus on the needs of the child with disabilities or developmental delay and improve the coordination of all forms of service and care for the child and the child's family.¹⁰ The pediatrician's role in IEP and IFSP development and implementation includes knowledge of federal statutes and state and local mandates and regulations; establishing linkages with local early intervention and education professionals and parental support groups; and collaborating with the team serving the individual child. Collaboration among parents, pediatricians, and educators can lead to better quality of care and paves the way for a better quality of life for the child and young adult with a disability.

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The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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INDIVIDUALIZED HEALTHCARE PLAN FOR PROGRAM/SCHOOL

This form is to be completed by your child's physician. If you provide the school with a SKIP form, complete the bottom section to let school or program personnel know who has access to the SKIP form at school in case of an emergency.

CONFIDENTIAL

For _____ Child's Full Name _____ Date of Birth _____

Written on _____ Date _____ by _____ Name / Degrees _____ Position _____

_____ has a health condition of which you as his/her teacher need to be aware. The description of this problem, as well as emergency care and individual considerations, is stated below. Keep this information so it is available to substitute teachers. Please feel free to contact me if you have any questions.

MEDICAL DIAGNOSIS / CONDITION: _____

SIGNS / SYMPTOMS:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

SUGGESTED ACTION:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

INDIVIDUAL CONSIDERATION: _____

Parent/guardian: _____ Home: _____ Work: _____

Physician: _____ Phone: _____ Hospital: _____

Other contact person: _____ Relationship: _____ Phone: _____

FOR EMERGENCY

The SKIP form (medical information to give to the ambulance emergency medical personnel), is held by

Name _____ Position _____ Location/telephone number _____

If the person IS NOT available please contact

Name _____ Position _____ Location/telephone number _____

PHYSICIAN'S ORDERS FOR SPECIALIZED HEALTH CARE PROCEDURES AT PROGRAM/SCHOOL

This form may be used as a guide for obtaining written orders from your child's physician. It is important to remember that physician's orders are necessary if

- your child needs assistance with performing a health care procedure
- your child needs a health care procedure to be performed by a school personnel

Each medicine or procedure requires a separate form.

Student's name: _____ Date of birth: _____

Program/school: _____

Address: _____

Procedure: _____

Who is responsible for performing procedure/assisting : _____

Date and duration of procedure: _____

Other recommendations: _____

Parent/guardian's signature: _____ Date: _____

Physician name: _____

Physician's signature: _____ Date: _____

Address: _____

Phone: _____

ADAPTIVE PHYSICAL EDUCATION RECOMMENDATION

To be completed by physician

This form is to be completed by your physician if your child's physical education activities are restricted. This form is to be used to consult at your child's IEP Team (m-team) meeting.

Student's name: _____ Date of birth: _____ School: _____

_____ is a patient of mine, and is unable to participate in physical education activities due to activity intolerance related to:

_____ Anatomic impairment: (cardiac/other) _____

_____ Developmental delay: (physical maturation/other) _____

_____ Health status, altered: (general/body/muscular weakness secondary to) _____

_____ Oxygen supply/demand imbalance, secondary to: _____

_____ Physiology, altered: (breathing pattern, ineffective/other) _____

_____ Other (specify diagnosis or description of the condition) _____

Condition: Permanent _____

Temporary _____

If temporary, may return to unrestricted activity _____ (Date)

.....
Functional restrictions: Child's condition is such that the intensity and type of activity should be limited. S(he) is capable of participation to the extent of:

_____ Unrestricted physical activity

_____ No competitive sports; in other activities, should stop short of excessive fatigue and undue stress.

_____ No contact sports, other activity allowed.

_____ Moderate exercise, with all running, jumping and gymnastics excluded.

_____ Minimal activity, training in coordination only. Simple, nonstrenuous activity.

_____ Recommend the following exercise: _____

.....
Musculoskeletal restriction:

_____ Avoid activities involving upper extremities.

_____ Avoid activities involving neck, back or abdomen.

_____ Avoid activities involving the lower extremities.

Comments: Attached are recommendations and/or orders that will assist the school system on developing a health management plan and an adaptive physical education program for this child.

Physician signature

Phone number

Date

MEDICAL INFORMATION FOR SCHOOL/PROGRAM

This will help you keep a record of your child's regular or scheduled eye and hearing exams and speech/language tests.

Remember to update this information as often as necessary. Child's Name: _____

Eye Exams

<u>Date</u>	<u>Results</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Hearing Exams

<u>Date</u>	<u>Results</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Speech/Language Tests

<u>Date</u>	<u>Test administered</u>	<u>Results</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER INFORMATION RELATED TO MY CHILD'S MEDICAL
CONDITION TO BE SHARED WITH PROGRAM/SCHOOL

The school has the authority to act only on physician's orders for your child. Additional information may be helpful to school personnel working with your child so that they may learn how to better assist your child. For example, sharing information about food preferences, best ways of dealing with equipment, sitting positions and recommended occupational or physical therapy / exercises with child.

Remember to update this information as often as necessary.

Child's Name: _____

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

REQUEST FOR SPECIALIZED HEALTH CARE FOR MY CHILD AT PROGRAM/SCHOOL

You as parent or guardian of your child, must give the school written authorization for:

- health care procedures performed by your child with assistance by school personnel
- health care procedures performed by school personnel on your child

It is also recommended that you provide the school with written authorization for your child to perform a health care procedure without assistance.

This form is only a request. Health school services usually have to be an IEP (m-team) meeting decision. For certain services, a child's insurance carrier provides services at child's school.

Child's name: _____ Date of birth: _____

I request that the following health care services be administered to my child: _____

I understand that a qualified designated person(s) will be administering the above mentioned health care services. It is my understanding that the following person(s) will be administering these health care services to my child using standardized procedures which have been approved by our physician:

Name	Address	Phone
_____	_____	_____
_____	_____	_____

I will notify the program/school immediately if the health status of my child changes, if there is a change in the procedure and/or if the procedure(s) are canceled.

Name of parent/guardian _____

Address _____

Phones where parent/guardian can be reached:

Home telephone number _____ Work telephone number _____ Other telephone number _____

Signature of parent/guardian _____ Date _____

PERMISSION TO RELEASE INFORMATION FROM PROGRAM/SCHOOL PERSONNEL TO PHYSICIAN

You may want Program/School personnel such as your child's school nurse, public health nurse or therapist to share medical or health related information with your physician about your child. This form gives permission for them to release information you specify below to your child's physician.

I do hereby authorize release of information to:

Physician/Institution Name _____

Address _____

City, State, Zip Code _____

Phone number _____

Student's name _____ Date of birth _____

Information Requested by Physician from Program/School

In order to develop a plan of management as well as to facilitate continuity of treatment for this child, it is important to obtain the following information:

	Parent/Guardian Initials		Parent/Guardian Initials
Behavioral Observations	_____	Nursing evaluations (e.g. I&O,	
Health Procedures at School	_____	BP, temp., wt., blood sugar)	_____
Individualized Health Plan/Individual	_____	Psychological evaluation	_____
Education Plan/Individualized	_____	Psychosocial evaluation	_____
Family Service Plan/ 504 Plan	_____	Treatment plans	_____
Informal observations/progress notes	_____	Tests	_____
Medication record	_____		

Other: _____

This information is confidential and shall only be viewed by the individuals listed below:

Name: _____ Position: _____

Name: _____ Position: _____

Name: _____ Position: _____

Name: _____ Position: _____

Parent/guardian signature _____

Date _____

PERMISSION TO RELEASE INFORMATION FROM PHYSICIAN TO PROGRAM/SCHOOL PERSONNEL

You may want your physician to share medical or health-related information with school or program personnel. This form gives written permission for your child's physician to release information to school or program personnel.

I do hereby authorize release of information to:

Name/Institution _____

Address _____

City, State, Zip Code _____

Phone number _____

Student's name _____ Date of birth _____

Information Requested by School Health Nurse

In order to develop an Individualized Health and/or Individual Education Plan as well as to facilitate continuity of treatment for this student, it is important to obtain the following information:

Please include the following information: Parent/Guardian Initials

- ☐ Diagnosis _____
- ☐ Date seen by physician(s) _____
- ☐ Treatment and progress _____
- ☐ Prognosis _____
- ☐ Recommendations for handling this health need at school _____

Parent/Guardian Initials

- ☐ Discharge summary _____
- ☐ Information observation/ progress notes _____
- ☐ Laboratory tests _____
- ☐ Neurological evaluation _____
- ☐ Physical examination _____

Parent/Guardian Initials

- ☐ Physician orders for procedures at school _____
- ☐ Psychiatric evaluation _____
- ☐ Psychological evaluation _____
- ☐ Treatment plans/plan of management _____

Other: _____

This information is confidential and may be viewed by the following personnel directly involved in the welfare of my child. Please specify who may view the information, (e.g. my child's teacher, principal, persons in the Department of Special Education):

Parent/Guardian Initials

Name: _____ Position: _____

Name: _____ Position: _____

This information remains in a secured location in the school health service office.

This information may also be filed in: ☐ Child's cumulative record _____
☐ Other: (please specify) _____

Parent/guardian signature _____

Date _____

PROGRAM/SCHOOL MEDICAL EMERGENCY PLANS CHECKLIST FOR FAMILIES

This is a checklist of information your family will want to review and discuss with school personnel in order to make sure everyone is aware of what will happen if your child has a medical emergency.

Remember to update this information as often as necessary. Child's Name: _____

- ☐ 1. Find out who keeps your child's SKIP form (medical information to give to the ambulance emergency medical personnel):

Name	Position	Location / telephone number
------	----------	-----------------------------

Find out who is the backup person to be contacted if the above named person is not available at the time of an emergency:

Name	Position	Location / telephone number
------	----------	-----------------------------

- ☐ 2. Inform your child's program/school whom you want the program/school to call in an emergency (family members, individuals having power of attorney, etc.)
Call 911
Call the following ambulance company:

Ambulance company name	Telephone
------------------------	-----------

- ☐ 3. Ask if your child's program/school posts directions for program/school personnel on what information should be reported at the time an emergency call is made:
name and position of person calling
program/school name and address
name of child and description of problem
stay on the line with the emergency personnel

- ☐ 4. Identify the school's **FIRST RESPONDERS** (The program/school personnel who are to be notified in an emergency. They are trained in CPR and first aid.)

Name	Position	How to reach
------	----------	--------------

CPR _____

FIRST AID _____

- ☐ 5. Inform the program/school of the names, relationships and phone numbers of individuals to be notified in the event of an emergency.

Name	Relationship to child	Telephone
------	-----------------------	-----------

At school, it is the responsibility of the **FIRST RESPONDER PROGRAM** to have a school official meet the emergency medical team (EMT) and direct them to the child.

- ☐ 6. Discuss with program/school personnel arrangements for transporting your child to a hospital by ambulance.

Who will accompany your child to the hospital? _____

What is the name and address of the hospital where your child will receive care?

Hospital name	Address
---------------	---------

PERMISSION TO TREAT

PURPOSE: Authorization for emergency treatment for children who become ill or injured, when parents cannot be reached.**

Child's name: _____ Date of birth: _____

In the event reasonable attempts to contact me at _____ Phone _____ or _____ Phone _____

or _____ have been unsuccessful, please contact:
_____ phone _____

Name Phone Relationship to child

Name Phone R
relationship to child

If those attempts have been unsuccessful,* I hereby give my consent for the administration of any treatment deemed necessary by

Dr. _____ (Preferred physician) or Dr. _____ (Preferred dentist)

or in the event the designated preferred practitioner is not available, by another licensed physician or dentist.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained BEFORE THE SURGERY IS PERFORMED. Facts concerning the child's medical history including allergies, medications being taken and any physical impairment to which a physician should be alerted include: _____

In the event physicians, other persons named on this card, or parents cannot be contacted, the officials at _____

_____ are hereby authorized to
(Name of school, scout program, recreational program, etc.)
take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.

I will not hold the _____ financially responsible for
(Name of school, scout program, recreational program, etc.)
the emergency care and/or transportation for said child.

Parent/Guardian Signature: _____ Date: _____

Address: _____ Phone: _____

City, State: _____ Zip code: _____

This form must be signed and notarized. This form is valid until either the child turns 18 years or age (Age of Accountability) or until the parent notifies the hospital in writing that the form is no longer valid.

State of Tennessee County of _____

Sworn before me this _____ day of _____

NOTARY PUBLIC _____


MY COMMISSION EXPIRES: _____

** Please attach a copy of your insurance card.

* Term for "unsuccessful" to be identified and defined by Legal Counsel.

Seal Here

Emergency Information Form for Children With Special Needs

 American College of
Emergency Physicians*

American Academy
of Pediatrics



Date form
completed
By Whom

Revised
Revised

Initials
Initials

Last name:

Name:		Birth date:	Nickname:
Home Address:		Home/Work Phone:	
Parent/Guardian:	Emergency Contact Names & Relationship:		
Signature/Consent*:			
Primary Language:	Phone Number(s):		
Physicians:			
Primary care physician:		Emergency Phone:	
		Fax:	
Current Specialty physician: Specialty:		Emergency Phone:	
		Fax:	
Current Specialty physician: Specialty:		Emergency Phone:	
		Fax:	
Anticipated Primary ED:		Pharmacy:	
Anticipated Tertiary Care Center:			

Diagnoses/Past Procedures/Physical Exam:	
1.	Baseline physical findings:
2.	
3.	Baseline vital signs:
4.	
Synopsis	
	Baseline neurological status:

Last name:

Diagnoses/Past Procedures/Physical Exam continued:	
Medications: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	Significant baseline ancillary findings (lab, x-ray, ECG): _____ _____ _____ Prostheses/Appliances/Advanced Technology Devices: _____ _____

Management Data:	
Allergies: Medications/Foods to be avoided 1. _____ 2. _____ 3. _____	and why: _____ _____ _____
Procedures to be avoided 1. _____ 2. _____ 3. _____	and why: _____ _____ _____

Immunizations											
Dates							Dates				
DPT							Hep B				
OPV							Varicella				
MMR							TB status				
H1B							Other				

Antibiotic prophylaxis: _____ Indication: _____ Medication and dose: _____

Common Presenting Problems/Findings With Specific Suggested Managements		
Problem	Suggested Diagnostic Studies	Treatment Considerations

Comments on child, family, or other specific medical issues:	
Physician/Provider Signature: _____	Print Name: _____

Attachment I

Draft Best Practice Guidelines for Mental Health Services

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TDMHDD Guideline
Schizophrenia

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TDMHDD Guideline

Schizophrenia in Children and Adolescents

Introduction

The guidelines presented here are designed to assist in the evaluation and treatment of children and adolescents with schizophrenic symptoms in the primary care setting. These guidelines are adapted from the following sources:

Practice parameters for the assessment and treatment of children and adolescents with schizophrenia. J Am Acad Child Adolesc Psychiatry 1994 Jun;33(5):616-35 [90 references]

The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations. 1998. Agency for Healthcare Quality and Research, Rockville, MD.
<http://www.ahrq.gov/clinic/schzrec.htm>

The user may wish to refer to the source material for complete texts, annotations, and references

The goal of this protocol is to improve the care of children/adolescents with schizophrenia and aid practitioners in the difficult task of diagnosis and then choosing the correct treatment for each individual child.

These guidelines are not intended to define or serve as a standard of medical care. Many children and adolescents have comorbid psychiatric disorders, and it is necessary to consider each case individually.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or otherwise from a legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age 16 or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

Tennessee law, effective March 1, 2000, permits a provider of routine health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. Acceptance of surrogate decision making is not mandatory, and is applicable only when the service recipient reasonably is determined to lack capacity to make treatment decisions,¹ because of mental retardation or developmental disability.²

Also effective March 1, 2000, Tennessee Code requires inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity. The committee may not, however, over-ride the decision of the recipient's guardian or conservator.³

1 See TDMHDD Rule 0940 xxxx

2 Tennessee Code Annotated § 33-3-218 through 220

3 Tennessee Code Annotated § 33-6-107 et. seq

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TDMHDD Guideline
Schizophrenia

Differential Diagnosis

- | | |
|--|---|
| Bipolar Disorder | Developmental Language Disorders |
| Schizoaffective Disorders | Obsessive-Compulsive Disorder |
| Other Psychotic Disorders | Factitious Disorder |
| Pervasive Developmental Disorders | Substance abuse disorders |
| Non-psychotic behavioral and/or emotional disorders | Personality Disorder |
| Organic Disorders | <ul style="list-style-type: none"> • paranoid • borderline • schizotypal • schizoid |
| <ul style="list-style-type: none"> • delirium • seizure • CNS lesion • neurodegenerative • metabolic • toxic encephalopathy • infectious diseases | |

DSM-IV Criteria

A. At least 2 of the following must be present for a significant period of time during a 1-month period:

- delusions
- hallucinations
- disorganized speech
- grossly disorganized or catatonic behavior
- negative symptoms (flattened affect, paucity of thought or speech).

Only one symptom need be present if the delusions are bizarre, the hallucinations include a voice providing a running commentary on the person's behavior or thinking, or 2 or more voices are conversing with each other.

B. In children and adolescents, failure to achieve expected level of interpersonal, academic, or occupational achievement

C. The disturbances must be present for a period of at least 6 months, which period must include 1 month (less, if successfully treated) of active-phase symptoms described above, which may include residual or prodromal symptoms.

D. Schizoaffective Disorder and Mood Disorder with Psychotic Features are ruled out

E. The disturbance is not due to the direct physiological effects of a substance or a general medical condition

F. Where there is a history of Autistic or other Pervasive Developmental Disorder, delusions or hallucinations are also present for at least one month (less, if successfully treated)

**TDMHDD Guideline
Schizophrenia****DRAFT COPY****Evaluation**

Complete diagnostic assessment including a neurologic and thorough psychiatric evaluation, school information, and history

- Premorbid History (prenatal, developmental, personality, highest LOF)
- History of present illness (DSM-IV target symptoms; course of illness, including onset, cyclical patterns, precipitating stressors; associated or compounding symptoms, especially mood disturbances, substance abuse, and organic factors)
- Physical evaluation
- Family history (environment, interactions, coping styles, resources, strengths; history of psychiatric and neurological conditions, and substance abuse)
- School functioning
- Suspected skills deficits

Rule out other disorders and determine if necessary to hospitalize

Identify other pertinent issues that will require ongoing treatment (family dysfunction, school difficulties, comorbid disorders)

Treatment Overview

Multimodal psychoterapeutic interventions include:

- 1) medication management
- 2) periodic diagnostic reassessments to ensure accuracy of diagnosis
- 3) appropriate psychotherapy
- 4) psychoeducational services for the patient
- 5) supportive services for the family
- 6) educational and vocational services
- 7) residential services when indicated

Medication TherapyAcute phase

Before initiating antipsychotic therapy, a thorough psychiatric evaluation is needed, which should include documentation of the psychotic symptoms targeted for the therapy. Preexisting abnormal movements should also be noted. Informed consent is needed from the parent and adolescent patients, while consent, when possible, should be obtained from preadolescents.

The choice of antipsychotic medication should be made based on the agent's relative potency, spectrum of side effects, and history of medication response in the patient and his or her family. Side effects noted with all antipsychotics (except clozapine) include extrapyramidal symptoms, anticholinergic symptoms, withdrawal dyskinesia, tardive dyskinesia, and neuroleptic malignant syndrome. There are also side effects specific to a particular agent, such as lenticular stippling with thioridazine, that need to be monitored when the agent is used.

When using antipsychotics, antiparkinsonian agents may be needed for the treatment of extrapyramidal side effects. Prophylactic use of antiparkinsonian agents should be considered in situations where extrapyramidal symptoms are likely, such as when using high-potency neuroleptics, when treating new patients, or when treating paranoid patients in whom a dystonic reaction may significantly impair compliance.

TDMHDD Guideline
Schizophrenia

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First-line drugs of choice include: **Olanzapine, Quetiapine, or Risperidone**. To determine whether or not antipsychotic medication is effective, it must be used for at least 4 to 6 weeks at adequate dosages. If no effects are seen at that point, consideration should be given to changing to a different class of antipsychotic medication.

Recovery phase

Once the acute psychotic symptoms are stabilized, the patient may still have ongoing difficulties with confusion, disorganization, motivation, and possible dysphoria. Antipsychotic medication should be maintained through this phase to prevent acute exacerbations. The goal of therapy is to reintegrate the patient back to his or her home and school, if possible.

Residual or remission phase

The patient should be maintained on the lowest effective dose of antipsychotic medication. Once the patient is clinically stable, the dosages should be reassessed approximately every 6 months. Many patients will be chronically impaired and need to be maintained on long-term antipsychotic agents.

When discontinuing these agents, they should be tapered, given the increased risk in children for withdrawal dyskinesia. The exception to this is when neuroleptic malignant syndrome occurs. Careful monitoring is needed during times in which the dosage is being changed to assess for symptoms of relapse.

Longitudinal medication management is needed to monitor side effects, including tardive dyskinesia.

Relapse of symptoms

When a patient relapses, it should first be determined whether or not the patient was compliant with his or her antipsychotic medications. If not, resumption of the medication should occur. The drugs of choice for non-compliant patients are Haloperidol Decanoate or Fluphenazine Decanoate because of the availability of a depot injection every 3 weeks. **Depot injections are not recommended for children and are only recommended for adolescents with documented chronic psychotic symptoms and a history of poor medication compliance.**

If the patient was compliant and had been previously responding and tolerating the agent, an increase in the medication dose may stabilize the psychotic symptoms (keeping in mind the standard dosage ranges).

If symptoms relapse and the patient is not adequately responding to the current antipsychotic agent (while being used at adequate dosages), a trial of a different neuroleptic should then be undertaken.

Patients who relapse may require acute hospitalization. This decision should be based on the severity of psychotic symptoms, potential danger to self or others, degree of impairment in the patient's ability to maintain basic self-care, and the availability of supportive services in the community.

Patients who do not respond to antipsychotics

Before it is decided that the patient is a non-responder, the patient must receive at least two adequate trials of different antipsychotic agents.

In adults, there are reports of successfully augmenting antipsychotic therapy with lithium, anticonvulsants, benzodiazepines, and fluoxetine. However, these are yet unproven and have not been studied in children and adolescents.

There are reports of clozapine being used successfully for adolescents with schizophrenia, however, in the United States, there is little experience with its use in patients younger than 16 years of age. If it is to be used, close monitoring for potential seizures, agranulocytosis (with periodic blood cell counts), and weight gain is necessary.

**TDMHDD Guideline
Schizophrenia****DRAFT COPY**

Adjunctive pharmacotherapies should be considered in patients who experience persistent and clinically significant associated symptoms of anxiety, depression, or hostility, despite an adequate reduction in positive symptoms with antipsychotic therapy.

Other Treatment Modalities to be ConsideredPsychosocial therapy

Support, education, and behavioral and cognitive skills training to address the specific deficits of persons with schizophrenia, to improve functioning and address other problems. Psychodynamic models are not recommended.

Patients who have ongoing contact with their families should be offered a family psychosocial intervention that spans at least 9 months and provides a combination of education about the illness, family support, crisis intervention, and problem-solving skills training. Such interventions should also be offered to non-family caregivers.

Psychoeducational therapy

for the patient, includes cognitive-behavioral strategies, such as social skills and problem-solving skills, and ongoing education about the illness, medication effects, and basic life skills training.

for the family promotes understanding of the illness, treatment options, and prognosis and development of strategies to cope with the symptoms of the patient.

Psychotherapy

- Individual (usually supportive rather than insight-oriented)
- Group
- Family (therapies based on the premise that family dysfunction is the etiology of the patient's schizophrenic disorder *should not* be used.)

Treatment of associated disorders or symptoms, such as substance abuse disorder, depression, or suicidality.

Partial hospitalization or day treatment programs. Specialized educational and psychiatric services available in either a hospital outpatient setting or a day treatment program that enable the individual to function at home and in community settings

Residential treatment

Severe circumstances or poor response to treatment may indicate the need for more restrictive care in an inpatient or residential setting, when less restrictive alternatives must have been unsuccessful. Ongoing assessment is needed, and the individual should return to the least restrictive treatment setting practicable, whenever possible.

Psychosocial Rehabilitation

Effective treatment may require a flexible array of services and supports, including case management, in-home services, family support, and school-based services. Supports and services of this kind are individualized and are designed to ameliorate the physical, mental, cognitive or developmental effects of schizophrenia

Systems of care serving persons with schizophrenia who are high service users should include assertive case

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Schizophrenia****DRAFT COPY**

management and assertive community treatment programs. These programs should be targeted to individuals at high risk for repeated rehospitalizations or who have been difficult to retain in active treatment with more traditional types of services.

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TDMHDD Guideline
Anxiety Disorders

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TDMHDD Guideline

Anxiety Disorders in Children and Adolescents

Introduction

The guidelines presented here are designed to assist in the evaluation and treatment of children and adolescents with anxiety disorders in the primary care setting. These guidelines are based on the following source material:

Practice parameters for the assessment and treatment of children and adolescents with anxiety disorders. J Am Acad Child Adolesc Psychiatry 1997 Oct;36(10 Suppl):69S-84S [161 references]

The user may wish to refer to the source material for complete text, annotations, and references.

The goal of this protocol is to improve the care of children/adolescents with conduct disorder and aid practitioners in diagnosis and treatment selection.

These guidelines are not intended to define or serve as a standard of medical care.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or otherwise from a legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age 16 or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

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Also effective March 1, 2000, Tennessee Code requires inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity. The committee may not, however, over-ride the decision of the recipient's guardian or conservator.³

1. See TDMHDD Rule 0940 xxxx

2. Tennessee Code Annotated § 33-3-218 through 220

3. Tennessee Code Annotated § 33-6-107 et. seq.

**TDMHDD Guideline
Anxiety Disorders**

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Differential Diagnosis

Hypoglycemic episodes	Medication reaction: antihistamines,
Hyperthyroidism	antiasthmatics, sympathomimetics,
Cardiac arrhythmias	steroids, haloperidol, pimozide, SSRIs,
Caffeinism	antipsychotics, OTC's (diet pills, cold
Pheochromocytoma	medicines, etc.)
Seizure disorders	Mood disorders
Migraine	ADHD
CNS disorders- delirium, brain tumor	Substance abuse disorders
Personality disorders	Eating disorders
Pervasive developmental disorders	Schizophrenia

DSM-IV Criteria

Generalized Anxiety Disorder

1. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
2. The person finds it difficult to control the worry.
3. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months).

Note: Only one item is required in children.

1. restlessness or feeling keyed up or on edge
 2. being easily fatigued
 3. difficulty concentrating or mind going blank
 4. irritability
 5. muscle tension
 6. sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
4. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.
 5. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
 6. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

**TDMHDD Guideline
Anxiety Disorders**

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Social Phobia**

- A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. Note: In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.
- B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed Panic Attack. Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.
- C. The person recognizes that the fear is excessive or unreasonable. Note: In children, this feature may be absent.
- D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress.
- E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
- F. In individuals under age 18 years, the duration is at least 6 months.
- G. The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., Panic Disorder With or Without Agoraphobia, Separation Anxiety Disorder, Body Dysmorphic Disorder, a Pervasive Developmental Disorder, or Schizoid Personality Disorder).
- H. If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it, e.g., the fear is not of Stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in Anorexia Nervosa or Bulimia Nervosa.

Panic Disorder

- A. A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:
 - 1. palpitations, pounding heart, or accelerated heart rate
 - 2. sweating
 - 3. trembling or shaking
 - 4. sensations of shortness of breath or smothering
 - 5. feeling of choking
 - 6. chest pain or discomfort
 - 7. nausea or abdominal distress
 - 8. feeling dizzy, unsteady, lightheaded, or faint
 - 9. derealization (feelings of unreality) or depersonalization (being detached from oneself)
 - 10. fear of losing control or going crazy
 - 11. fear of dying
 - 12. paresthesias (numbness or tingling sensations)
 - 13. chills or hot flushes
- B. At least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:
 - 1. persistent concern about having additional attacks
 - 2. worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy")
 - 3. a significant change in behavior related to the attacks
- C. The Panic Attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).

**TDMHDD Guideline
Anxiety Disorders**

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- D. The Panic Attacks are not better accounted for by another mental disorder, such as Social Phobia (e.g., occurring on exposure to feared social situations), Specific Phobia (e.g., on exposure to a specific phobic situation), Obsessive-Compulsive Disorder (e.g., on exposure to dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., in response to stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., in response to being away from home or close relatives).

Obsessive-Compulsive Disorder

- A. Either obsessions or compulsions:

Obsessions as defined by (1), (2), (3), and (4):

1. recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress
2. the thoughts, impulses, or images are not simply excessive worries about real-life problems
3. the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action
4. the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

Compulsions as defined by (1) and (2):

1. repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly
 2. the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive
- B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. **Note:** This does not apply to children.
- C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.
- D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).
- E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Posttraumatic stress disorder- (see full guideline in this manual for additional information)

- A. The person has been exposed to a traumatic event in which both of the following were present:
1. the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
 2. the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior
- B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
 2. recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
 3. acting or feeling as if the traumatic event were recurring (includes a sense of reliving the

**TDMHDD Guideline
Anxiety Disorders**

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- experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated) **Note:** In young children, trauma-specific reenactment may occur.
- 4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- 5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
 - 1. efforts to avoid thoughts, feelings, or conversations associated with the trauma
 - 2. efforts to avoid activities, places, or people that arouse recollections of the trauma
 - 3. inability to recall an important aspect of the trauma
 - 4. markedly diminished interest or participation in significant activities
 - 5. feeling of detachment or estrangement from others
 - 6. restricted range of affect (e.g., unable to have loving feelings)
 - 7. sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
 - 1. difficulty falling or staying asleep
 - 2. irritability or outbursts of anger
 - 3. difficulty concentrating
 - 4. hypervigilance
 - 5. exaggerated startle response
- E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Other phobias

- A. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).
- B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed Panic Attack. **Note:** In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging.
- C. The person recognizes that the fear is excessive or unreasonable. **Note:** In children, this feature may be absent.
- D. The phobic situation(s) is avoided or else is endured with intense anxiety or distress.
- E. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
- F. In individuals under age 18 years, the duration is at least 6 months.
- G. The anxiety, Panic Attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as Obsessive-Compulsive Disorder (e.g., fear of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor), Separation Anxiety Disorder (e.g., avoidance of school), Social Phobia (e.g., avoidance of social situations because of fear of embarrassment), Panic Disorder With Agoraphobia, or Agoraphobia Without History of Panic Disorder

**TDMHDD Guideline
Anxiety Disorders**

DRAFT COPY**Separation anxiety**

- A. Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three (or more) of the following:
 - 1. recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated
 - 2. persistent and excessive worry about losing, or about possible harm befalling, major attachment figures
 - 3. persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)
 - 4. persistent reluctance or refusal to go to school or elsewhere because of fear of separation
 - 5. persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings
 - 6. persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
 - 7. repeated nightmares involving the theme of separation
 - 8. repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated
- B. The duration of the disturbance is at least 4 weeks.
- C. The onset is before age 18 years.
- D. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.
- E. The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and, in adolescents and adults, is not better accounted for by Panic Disorder With Agoraphobia.

Behavioral Treatment

Behavioral therapy targets the patient's overt behavior and emphasizes treatment within the context of family and school instead of focusing on the etiology of the behavior.

Cognitive-behavioral treatment integrates a behavioral approach with an emphasis on changing the cognitions associated with the patient's anxiety.

Psychodynamic psychotherapy includes a greater participation of the parents/caregivers and a more explicit use of active support, practical guidance, and environmental interventions.

Parent-child interventions may include helping parents/caregivers encourage children/adolescents to face new situations rather than withdrawing, refraining from excessive criticism and intrusiveness, responding to children's needs, and encouraging children to engage in activities despite anxiety. Infant-parent psychotherapy is recommended where there are attachment problems.

Family therapy is also used to disrupt the dysfunctional family interactional patterns that promote family insecurity and to support areas of family competence.

Psychoeducation is important in treatment of panic disorder.

Pharmacological Treatment

Pharmacotherapy should never be used as the sole intervention. Pharmacotherapy should be used only as an adjunct to behavioral or psychotherapeutic interventions. Selection of the appropriate medication is primarily based on comorbid conditions if they exist. For a child/adolescent with ADHD or enuresis, a tricyclic antidepressant is the drug of choice. A child with comorbid obsessive-compulsive disorder would benefit the most from an SSRI. Side effect profile should also be considered when selecting medication therapy.

Benzodiazepines are often used on a short-term basis, and in the case of severe anxiety.

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Anxiety Disorders**

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benzodiazepines may be used in conjunction with an SSRI or TCA for several weeks until the antidepressant begins to show beneficial effects.

Treatment Steps

1. Determine onset and development of symptoms and the context in which the symptoms occur and are maintained.
 - a. Is anxiety stimulus specific, spontaneous, or anticipatory?
 - b. Is avoidant behavior present?
 - c. Do comorbid symptoms exist?
2. Explore patient's development history including temperament, ability to soothe self or be soothed, quality of attachment, adaptability, stranger and separation responses, childhood fears.
3. Obtain medical history, medication history, school history, social history, and family history.
4. Interview patient and conduct a mental status exam.
5. Conduct family assessment and parent-child relationship.
6. Refer for IQ, psychological, learning disability, and speech and language testing if indicated.
7. Establish diagnosis
 - a. Consider physical conditions that may mimic anxiety disorders.
 - b. Screen for psychiatric disorders that may be comorbid with or misdiagnosed as anxiety disorders.
 - c. Consider that more than one anxiety disorder may be present.
8. Education of parents and other significant persons about symptoms, clinical course, treatment options, and prognosis.
9. Consult and collaborate with school personnel.
10. Begin behavioral or psychotherapy depending on the diagnosis.
 - a. separation anxiety disorder-
 - behavioral program involving child/adolescent, parents, school personnel, and other appropriate persons
 - family interventions including family therapy, parent-child interventions, and parental guidance
 - psychotherapy including cognitive-behavioral therapy and psychodynamic psychotherapy
 - b. other anxiety disorders-
 - psychotherapy including cognitive-behavioral and behavioral therapy techniques
 - psychodynamic psychotherapy
 - family interventions
 - c. social phobia-
 - cognitive-behavioral therapy and behavioral therapy
 - individual or group psychotherapy
 - family intervention
 - d. other phobias-
 - behavioral and cognitive-behavioral therapy
 - complicated cases may require individual and group psychotherapy
 - e. panic disorder-
 - cognitive-behavioral therapy
 - individual psychodynamic, group, or family psychotherapies

**TDMHDD Guideline
Anxiety Disorders****DRAFT COPY**

- f. obsessive-compulsive disorder-
 - cognitive-behavioral therapy
 - therapist-assisted exposure and response prevention
 - g. posttraumatic stress disorder-
 - cognitive-behavioral therapy
 - exposure therapy
 - psychodynamic psychotherapy
 - family therapy
 - discussion groups or peer counseling groups
11. Begin pharmacotherapy depending on the diagnosis and severity.
- a. separation anxiety disorder- in severe cases use a benzodiazepine +/- TCA* or SSRI
 - b. other anxiety disorders- in severe cases use a benzodiazepine +/- TCA* or SSRI
 - c. social phobia- SSRI
 - d. other phobias- pharmacotherapy rarely used
 - e. panic disorder- SSRI or TCA +/- benzodiazepine
 - f. obsessive-compulsive disorder- SSRI or clomipramine
 - g. posttraumatic stress disorder- antidepressant of choice

*Trazodone is often effective in these cases

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TDMHDD Guideline
Conduct Disorder

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TDMHDD GUIDELINE**Evaluation and Treatment
of Conduct Disorder in Children and Adolescents****Introduction**

The guideline presented here is designed to assist in the evaluation and treatment of children and adolescents with conduct disorder in primary care and behavioral treatment settings. Portions of this guideline are based the following sources:

Practice parameters for the assessment and treatment of children and adolescents with conduct disorder. J Am Acad Child Adolesc Psychiatry 1997 Oct;36(10 Suppl):122S-139S [225 references]

Decision trees and essential outline materials were furnished by Martha Wike, Ph.D., Consulting Psychologist, Tennessee Department of Children's Services

The goal of this protocol is to improve the care of children/adolescents with conduct disorder and aid practitioners in diagnosis and treatment selection.

These guidelines are not intended to define or serve as a standard of medical care.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or otherwise from a legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age 16 or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

Tennessee law, effective March 1, 2000, permits a provider of routine health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. Acceptance of surrogate decision making is not mandatory, and is applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions,¹ because of mental retardation or developmental disability.²

Also effective March 1, 2000, Tennessee Code requires inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity. The committee may not, however, over-ride the decision of the recipient's guardian or conservator.³

1. See TDMHDD Rule 0940 ccc.

2. Tennessee Code Annotated § 33-3-218 through 220

3. Tennessee Code Annotated § 33-6-107 et seq.

TDMHDD Guideline Conduct Disorder

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Differential Diagnosis

Oppositional defiant disorder	Adjustment disorder
ADHD	Mood disorders
Substance abuse	Child or adolescent antisocial behavior
Medical disorders	Personality disorders
PTSD	Schizophrenia
Developmental disorders	

DSM-IV Criteria

Conduct Disorder, as defined by the DSM-IV, consists of a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:

- Must have 3 or more:
 - Aggression to people or animals
 - Destruction of property
 - Deceitfulness or theft
 - Serious violation of rules
 - In the past 12 months
 - With at least 1 in the past 3 months
- The disturbance in behavior causes clinically significant impairment
- If 18 or older, not Antisocial Personality

Assessment

- Patient interview (with and without parents)...assess mental status, impulse control, capacity for attachment, trust and empathy, tolerance for negative emotions
- Parent interview...assess developmental hx, family hx of mood and thought disorders, impulse control and substance abuse disorders, personality disorders
- Collateral contact interviews (school, court)
- Physical exam, including urine or blood drug screen, if drug use is suspected

Treatment

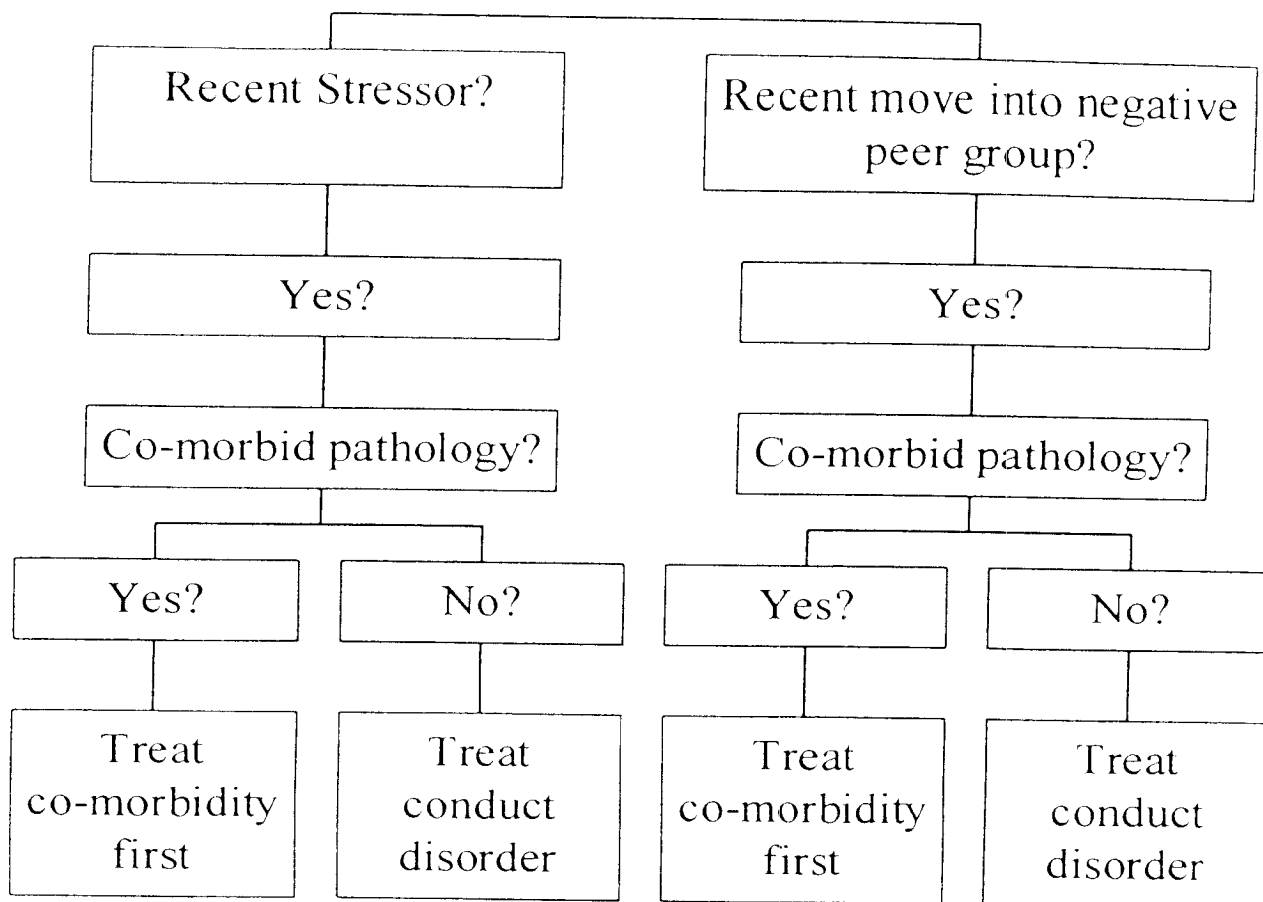
Treatment should be provided in a continuum of care that allows flexible application of modalities by a cohesive treatment team. Outpatient treatment of conduct disorder includes intervention in the family, school, and peer group.

- Treat comorbid disorder

**TDMHDD Guideline
Conduct Disorder****DRAFT COPY**

- *Family interventions* include parent guidance, skills training and family therapy.
 - Work on parenting strengths...eliminate too harsh and too permissive approaches
 - Treat parental pathology
- *Individual and group psychotherapy* with adolescent or child. The technique of intervention should be adapted to child's age, processing style, and ability to engage in treatment.
 - Group therapy is important with adolescents.
 - Individual therapy, alone, is ineffective
- *Psychosocial skill-building training.*
 - Child training to improve peer relationships
 - Child training to improve academic skills
 - Child training to improve compliance with demands from authority figures
 - Social skills building
- *Other psychosocial interventions* should be considered as indicated. Some interventions to consider are peer intervention, school intervention for appropriate placement, juvenile justice system intervention, social services, community resources, out-of-home placement, and job and independent-living skills training.
- *Psychopharmacology.* Medications are recommended only for treatment of target symptoms and comorbid disorders and are recommended only on the basis of clinical experience.
- *Level of care decision-making.* Level of care should be the least restrictive level of intervention that fulfills both the short and long-term needs of the patient.

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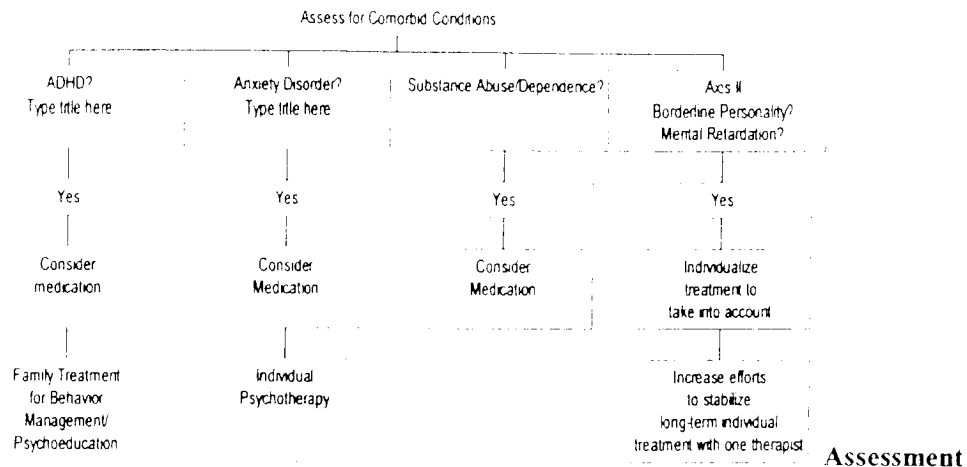
TDMHDD Guideline
Conduct Disorder

Decision Tree for Conduct Disorder

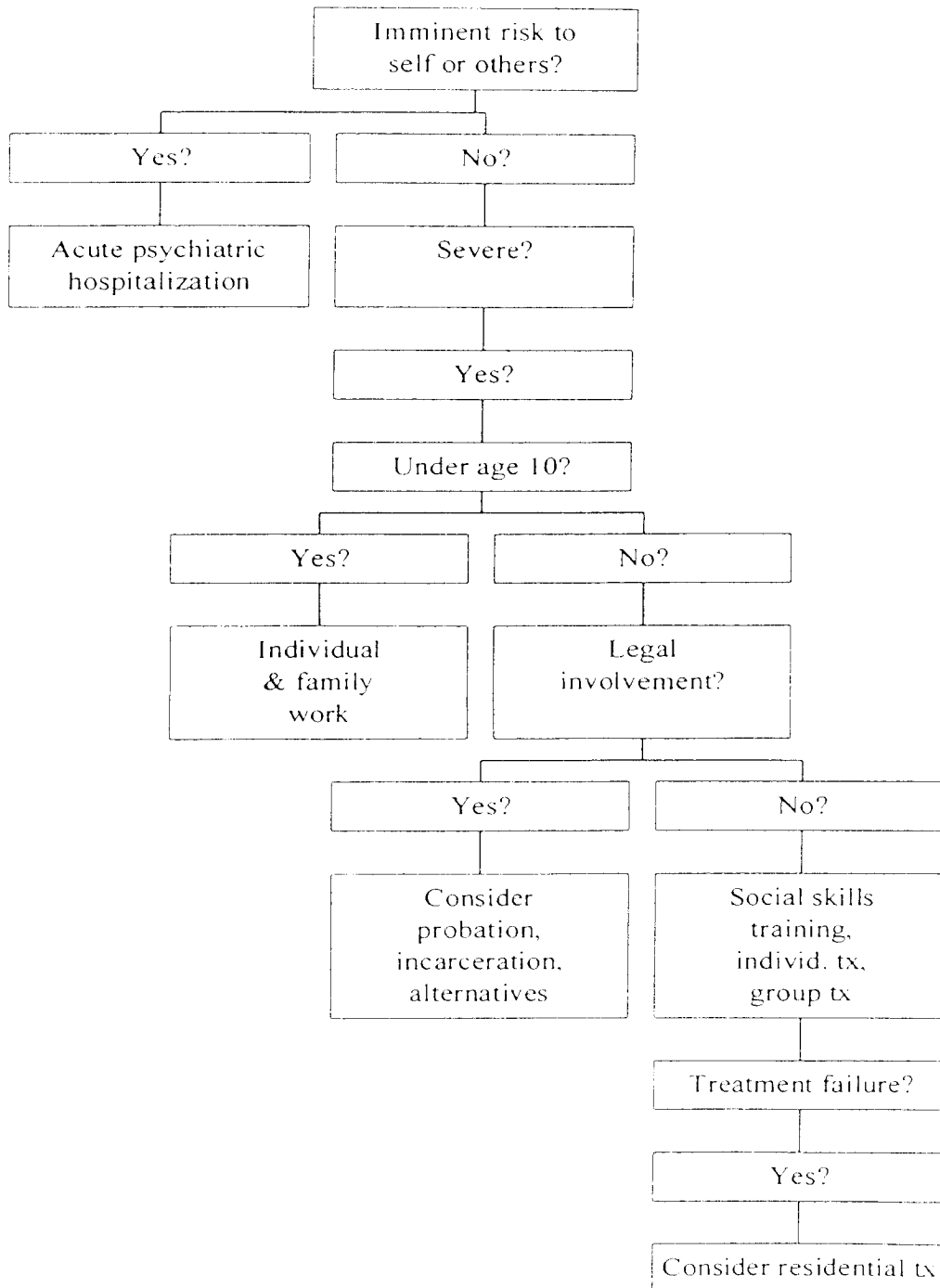
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TDMHDD Guideline
Conduct Disorder



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TDMHDD Guideline
Conduct Disorder**Conduct Disorder Treatment**

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TDMHDD Guideline
Depression

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TDMHDD GUIDELINE**Depression in Children and Adolescents****Introduction**

The guidelines presented here are designed to assist in the evaluation and treatment of children and adolescents with depressive disorders in the primary care setting. These guidelines are adapted from:

Practice parameters for the assessment and treatment of children and adolescents with depressive disorders. J Am Acad Child Adolesc Psychiatry 1998 Oct;37(10 Suppl):63S-83S [231 references]

The user may wish to consult the source material for complete texts, annotations, and references.

The goal of this protocol is to improve the care of children/adolescents with depression and aid practitioners in diagnosis and treatment selection.

These guidelines are not intended to define or serve as a standard of medical care.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or otherwise from a legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age 16 or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

Tennessee law, effective March 1, 2000, permits a provider of routine health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. Acceptance of surrogate decision making is not mandatory, and is applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions,¹ because of mental retardation or developmental disability.²

Also effective March 1, 2000, Tennessee Code requires inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity. The committee may not, however, over-ride the decision of the recipient's guardian or conservator.³

1. See TDMHDD Rule 0940 xxxx.

2. Tennessee Code Annotated § 33-3-218 through 220.

3. Tennessee Code Annotated § 33-6-107 et seq.

Assessment

- Comprehensive psychiatric diagnostic evaluation, including interviews with the child, parents, and collateral informants, such as teachers and social services personnel,
- Evaluation performed by a clinician trained to consider how developmental and cultural factors impact the patient's clinical presentation.
- Performance of a developmentally appropriate mental status examination (MSE), physical examination, laboratory tests
- Assessment of risk for suicidal behaviors

TDMHDD Guideline Depression

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- Global functioning assessment using scales such as the Children's Global Assessment Scale or the Global Assessment of Functioning.
- Identification of other pertinent issues that will require ongoing treatment (family dysfunction, school difficulties, comorbid disorders)
- Ongoing assessment

Differential Diagnosis

Anxiety disorders
Learning disabilities
Disruptive disorders
ADHD
Substance abuse
Personality disorder
Medical disorders

Adjustment disorder
Chronic fatigue syndrome
Bereavement
Anorexia nervosa
Premenstrual dysphoric disorder
Bipolar disorder
Eating disorders

DSM-IV Criteria for Major Depressive Disorder

Major Depressive Disorder (MDD), in general consists of:

- One or more Major Depressive Episodes, as defined below.
- Not better accounted for by Schizoaffective Disorder, and not superimposed on Schizophrenia, Schizophreniform, Delusional, or Psychotic Disorder, **and**

There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode (except as may have been induced by substance, treatment, or due to the direct physiological effect of a general medical condition)

A Major Depressive Episode, as defined by the DSM-IV, consists of either a depressed or irritable mood and/or a loss of interest or pleasure for at least 2 weeks, in addition to the presentation of 5 or more of the following symptoms:

- | | |
|--|---|
| <ul style="list-style-type: none"> • DEPRESSED MOOD MOST OF THE DAY, NEARLY EVERY DAY • mARKEDLY DIMINISHED INTEREST IN ACTIVITIES, MOST OF THE DAY, NEARLY EVERY DAY • sIGNIFICANT Weight loss/weight gain • Insomnia/hypersomnia | <ul style="list-style-type: none"> • Psychomotor retardation OR agitation • Decreased energy or motivation • Guilt feelings • Inability to concentrate • rECURRENT Thoughts of DEATH OR suicidal IDEATION, sUICIDE ATTEMPT OR PLAN |
|--|---|

TDMHDD Guideline Depression

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AND these symptoms:

<ul style="list-style-type: none"> • Social impairment or impairment in performance of activities • Unrelated to substance abuse 	<ul style="list-style-type: none"> • Unrelated to bereavement • Unrelated to medication use or other psychiatric illness
--	--

Treatment

Treatment Planning

- Develop treatment plan appropriate to developmental stage of child or adolescent
- Provide services in the least restrictive environment that provides safety and effectiveness

Acute Treatment

- The choice of initial therapy depends on
 - ♦ Chronicity
 - ♦ Severity and number of prior episodes
 - ♦ Contextual issues
 - ♦ Previous response to treatment
 - ♦ Age of patient
 - ♦ Compliance with treatment
 - ♦ Patient's and family's motivation for treatment
- Pharmacotherapy alone usually is not sufficient.
- The high degree of comorbidity and the severity of psychosocial and academic consequences of depression suggest a multi-modal treatment approach.
- Because depression usually runs in families it is important to assess and treat other family members and those who live with the patient.

Patient and Family Education

The patient and caregivers should be taught about the disease and the treatment involved. Family education involves them as informed partners in the treatment team, and helps them understand depression as an illness, identify and manage affect, address psychosocial deficits, and learn the importance of compliance with treatment. Participation by parents may help them identify their own depressive symptoms.

Psychotherapy

- *Psychodynamic psychotherapy* can help youth understand themselves, identify feelings, improve self-esteem, change maladaptive patterns of behavior, interact more effectively with others, and cope with ongoing and past conflicts.
- *CBT* is based on the premise that depressed patients have cognitive distortions in how they view themselves, the world, and the future; that these cognitive distortions contribute to their depression. CBT teaches patients to identify and counteract these distortions. Clinical studies found a high rate of relapse upon follow-up, suggesting the need for continuation treatment.

**TDMHDD Guideline
Depression****DRAFT COPY**

- *IPT* focuses on problem areas of grief, interpersonal roles, disputes, role transitions, and personal difficulties. *IPT* has been shown to be useful in the acute treatment of adolescents with MDD. The rate of relapse may be relatively low after acute *IPT* treatment

Antidepressant Medication

Pharmacotherapy alone is never sufficient as the sole treatment. Combined treatment promotes self-esteem, coping skills, adaptive strategies, and improved peer and family relationships.

Antidepressant medications seem indicated for children and adolescents with severe symptoms that prevent effective psychotherapy; whose symptoms fail to respond to an adequate trial of psychotherapy; with chronic or recurrent depression; and with psychotic or bipolar depressions.

Prior to initiating treatment, specific target symptoms should be defined with the patient and parents. They should be informed about side effects, dose schedule, the lag in onset of therapeutic effect, and the danger of overdose. Parents should maintain responsibility for storing and administering the medications to enhance compliance and minimize suicidal risk from overdose. Quantity of dispensed medications should be monitored carefully.

Selective serotonin reuptake inhibitors (SSRIs) are the initial antidepressants of choice for patients requiring pharmacotherapy, although the presence of comorbidities may require alternate initial agents or a combination of medications. There is no indication for laboratory tests before or during the administration of SSRIs.

SSRIs (Prozac, Zoloft, Paxil, and Celexa) are the drugs of choice because of their safety, side effect profile, ease of use, and suitability for long-term maintenance. Since improvement with the SSRIs may take 4 to 6 weeks, patients should be treated with adequate and tolerable doses for at least 4 weeks. At 4 weeks, if patients have not shown even minimal improvement, treatment should be modified (e.g., increase dose, change medications). If the patient shows improvement at 4 weeks, the dose should be continued for at least 6 weeks. The SSRIs have a relatively flat dose-response curve, suggesting that maximal clinical response may be achieved at minimum effective doses.

Tricyclic Antidepressants are not recommended as first line treatment for youth with depressive disorders because of the lack of efficacy and potential side effects. Nevertheless, individual patients may respond better to the TCAs than other medications. If Tricyclic Antidepressants (TCAs) are used, baseline electrocardiogram (EKG), resting blood pressure and pulse (supine or sitting, standing), and weight should be monitored regularly.

Augmentation agents may be indicated for children who are resistant to treatment or present complicating factors. Such agents may include:

- Trazodone
- Anticonvulsants
- Antimania medication
- ECT (only as authorized by statute. See T.C.A. 33-8-301 et seq.)
- Antipsychotic medication (for MDD with psychotic features)*

* See guideline on treatment of Schizophrenia for additional information on antipsychotic medication

**TDMHDD Guideline
Depression****DRAFT COPY***Continuation Phase*

- Continuation therapy is recommended for all patients for at least 6 months after remission.
- The patient and his or her family should be taught to recognize early signs of relapse.
- Continuation psychotherapy helps to foster medication compliance.
- Antidepressants must be continued at the same dose used to attain remission of acute symptoms.
- At the end of the continuation phase, for patients who do not require maintenance treatment, medications should be discontinued gradually.

Maintenance Therapy

Clinicians should consider maintenance therapy for patients with multiple or severe episodes of depression and those at high risk for recurrence. Factors associated with recurrence include a family history of bipolar disorder or recurrent depression, comorbid psychiatric disorders, stressful or non-supportive environments, and residual or subsyndromal symptomatology.

The treatments that were used to induce remission in the acute phase should be used for maintenance therapy. Youth with two or more episodes of depression should receive maintenance treatment for at least 1 to 3 years. Patients with recurrent episodes accompanied by psychosis, severe impairment, severe suicidality, and treatment-resistance, as well as patients with more than 3 episodes, should be considered for longer, even lifelong treatment.

The long-term effects of antidepressants on maturation and development of children have not been studied. The clinician and patient's family should therefore weigh the risks and benefits of pharmacotherapy in maintenance therapy.

DYSTHYMIC DISORDER**DSM-IV Criteria for Dysthymic Disorder (child or adolescent)**

- Depressed Mood, most of the day, more days than not, for at least one year
- Presence, while depressed, of two or more of the following
 - ♦ poor appetite or overeating
 - ♦ low energy or fatigue
 - ♦ low self-esteem
 - ♦ poor concentration or difficulty making decisions
 - ♦ feelings of hopelessness
- The foregoing symptoms have not abated for more than 2 months at a time during the year
- The disturbance is not better accounted for by MDD
- There has never been a manic, mixed, or hypomanic episode
- The disturbance does not occur exclusively in the course of a Psychotic Disorder
- The symptoms are not due to physiological effects of substance use or a general medical condition
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

**TDMHDD Guideline
Depression****DRAFT COPY****Treatment**

Clinical practice and theory support the use of psychotherapies of varying degrees of intensity, including psychoanalysis, psychodynamic psychotherapy, CBT, and IPT, to treat DD. In the absence of published studies of psychotherapeutic or pharmacologic treatment of children and adolescents with DD or comorbid MDD and DD, clinicians are advised to use interventions recommended for the treatment of youth with MDD.

PREVENTION

Youth with subclinical depressive symptoms are at high risk to develop clinical depression. When these symptoms persist after an episode of depression continuous treatment until full remission is recommended. For patients who have not had an episode of depression, psychosocial interventions to reduce environmental and family stressors and CBT strategies appear to be efficacious to prevent deterioration.

Children with DD usually have a first episode of MDD 2 to 3 years after the onset of the DD, suggesting that DD is a gateway to recurrent mood disorders and indicating the need for early intervention with mild to moderate depression. Early intervention with depressed youth also may avert the development of comorbid psychiatric disorders. For example, MDD often precedes the onset of substance use disorders and treatment of depression may prevent their development.

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TDMHDD Guideline
Mental Retardation and Comorbid Disorders

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TDMHDD Guideline**Mental Retardation and Comorbid Disorders
in Adults over 22 Years of Age****Introduction**

The guidelines presented here are designed to assist in the evaluation and treatment of children and adolescents who have mental disorders comorbid with mental retardation. These guidelines are adapted from the following sources:

Practice parameters for the assessment and treatment of children, adolescents, and adults with mental retardation and comorbid mental disorders. J Am Acad Child Adolesc Psychiatry 1999 Dec;38(12 Suppl):5S-31S [117 references]

Rush AJ, & Frances A., eds. *The Expert Consensus Guideline Series: Treatment of Psychiatric and Behavioral Problems in Mental Retardation.* American Journal on Mental Retardation 2000;105:159-228.

The user may wish to refer to the source material for complete text, annotations, and references

Goals of this Protocol:

1. To improve the care of children/adolescents, and young adults up to 21 to 22 years of age (an upper age limit of eligibility for public special education and related services in some states), who present mental retardation and possible comorbid disorders.
2. To aid practitioners in the difficult task of assessment and then choosing the correct treatment for each individual child. These guidelines are not intended to define or serve as a standard of medical care. Clinical management recommendations herein do not replace clinical judgement, tailored to the particular needs of each clinical situation.

Informed Consent

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¹ See TDMHDD Rule 0940, xxx x

² Tennessee Code Annotated § 33-3-218 through 220

³ Tennessee Code Annotated § 33-6-107 et seq.

Assessment and Diagnosis

Overview

Psychiatric and behavioral assessment of persons with MR includes:

- Comprehensive assessment of MR.
- Assessment of mental illness in persons with mental retardation, including comprehensive history, service recipient interview, medical review and diagnostic formulation.

Diagnosis of MR (Considerations, based on DSM-IV and AAMR criteria)

Criteria	Definition										
Significantly sub-average intellectual functioning	IQ approximately 70 or below										
Below average IQ causes limitations in adaptive skills and functioning in at least two of the following areas:	Communication, Self-direction, Self-care, Functional academic skills, Home living, Work, Social-interpersonal skills, Leisure, Use of community resources, Health and safety										
Age at onset	Must be evident before age 18										
Levels of severity (DSM-IV)	<table border="1"> <tr> <td>Mild</td><td>IQ 55-70</td></tr> <tr> <td>Moderate</td><td>IQ 40-55</td></tr> <tr> <td>Severe</td><td>IQ 25-40</td></tr> <tr> <td>Profound</td><td>IQ below 25</td></tr> <tr> <td>Unspecified</td><td>Strong presumption, but the individual's intelligence is untestable by standard instrument</td></tr> </table>	Mild	IQ 55-70	Moderate	IQ 40-55	Severe	IQ 25-40	Profound	IQ below 25	Unspecified	Strong presumption, but the individual's intelligence is untestable by standard instrument
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Unspecified	Strong presumption, but the individual's intelligence is untestable by standard instrument										
Levels of supports needed (AAMR)	Intermittent, Limited, Extensive, or Pervasive										
Be cautious in interpreting low IQ in the presence of a psychiatric disorder	Impairment in IQ must precede and not be directly related to psychiatric disorder										

Assessment of Mental Illness in Persons with MR

Mental illness is frequently comorbid with mental retardation, with most prevalence estimates ranging from 30% to 70%. Virtually all categories of mental disorders have been reported in this population.

However so, diagnostic precision, in the presence of MR, is not always feasible, and there is strong consensus opinion that specific psychiatric diagnosis is not routinely and reliably possible in more severe cases of MR. Many practitioners use medication only when there is a specific psychiatric diagnosis.

The psychiatric diagnostic evaluation of persons who have MR is in principle the same as for persons who do not have retardation. The diagnostic approaches are modified, depending on the service recipient's cognitive level and especially communication skills. For persons who have mild MR and good verbal skills the approach does not differ much from diagnosing persons with average cognitive skills. The poorer the communication skills, the more one has to depend on information provided by caregivers familiar with the service recipient and on direct behavioral observations.

TDMHDD Guideline
Mental Retardation and Comorbid Disorders

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Assessment Methods

Preferred methods of evaluation

Interview with family/caregivers

Medical history and physical examination

Medication and side effects evaluation

Direct observation of behavior

Functional behavioral assessment

Unstructured psychiatric diagnostic interview †

Also consider:

- Standardized rating scales
- Biomedical evaluation, including family, pregnancy, perinatal, developmental, health, social, and educational history; physical and neurodevelopmental examination; and laboratory tests. Laboratory tests are usually indicated by the findings in the history and physical examination and may include chromosomal analysis (including fragile-X by DNA analysis); brain imaging (CT scan, MRI); EEG; urinary amino-acids; blood organic acids and lead level; appropriate biochemical tests for inborn errors of metabolism.
- Standardized testing (e.g. intelligence, neuropsychological, language) ††

† Interview for mild/moderate MR; for more severe/permanent MR

†† In mild/moderate MR only.

Recipient and Caregiver Interview

The recipient may present communication deficits or may otherwise be shy in regard to disclosure of relevant history. Information from parents and caregivers should always be sought in order to develop a more complete assessment, especially in those instances where the recipient lacks adequate communication skills. Attempts should be made to collect both anecdotal subjective information and more objective data, such as daily record keeping or graphical data.

Comprehensive History Includes:

- Presenting symptoms/behaviors
- Assessment of functioning.
- Treatment history
- Placements and supports
- Family/household dynamics
- Past evaluations.

Recipient Interview:

- Ample time should be allotted for the service recipient interview. Sufficient time is needed to put the service recipient at ease.
- The interview should be adapted to the service recipient's communication skills
- Clear and concrete language should be used
- Reassurance and support should be provided
- Leading and yes/no questions should be avoided
- The interviewer should attempt to ensure that questions are understood.
- Mental status may be assessed from context of conversation, rather than by formal examination

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Mental Retardation and Comorbid Disorders

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- Nonverbal expression and activity should be considered

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Mental Retardation and Comorbid Disorders

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- **Medical Review**
 - Developmental history
 - Medical history
 - General medical disorders and treatments.

Evaluation of Stressors

Complete evaluation and individualized treatment requires attention to possible stressors that may be triggering or exacerbating the presenting problem in someone with MR. The stressors listed below may be more likely to occur in persons with MR, and cause difficulties for those who have reduced coping skills. Helping the individual, family, and caregivers deal with or eliminate stressors may sometimes be the primary target of treatment and often facilitates whatever other treatment interventions that are necessary.

Type of Stressor	Examples
Change	Moving, new school or job, change of routine, developmental milestones, <i>transition from developmental centers</i>
Interpersonal	Loss of significant other, displacement from job or school
Environmental	Crowding, noise, disorder, lack of stimulation, lack of privacy, work or school-related pressure
Parenting/Social Support	Lack of support from others; disruptive visits/contacts; neglect, hostility, physical or sexual abuse
Illness/Disability	Chronic illness, serious acute illness, sensory deficits, difficulty with ambulation, seizures
Stigmatization re problems	Being taunted, teased, excluded, bullied, or exploited
Frustration	Inability to communicate needs & wishes; lack of choice in living & work situations; self-awareness of deficits
Trauma	<i>Persons with mental retardation have higher rates of victimization</i>

Treatment

Generally

The habilitation of persons with MR is based on the principles of normalization and community based care, with additional supports as needed. Federal legislation, for example, the Individuals with Disabilities Education Act (IDEA), entitles disabled children and adolescents to a full range of diagnostic, educational and support services from birth to age 21. Specialized treatments are also provided if necessary, as is done for persons with severe visual and auditory impairment.

The parents of children and adolescents with MR are entitled by these laws to receive support services and to be active participants in treatment planning. Some parents and older patients are not aware of their rights to obtain services. The clinician has an important role in such instances to educate and, if needed, to refer to a "patient advocate" or "educational advocate."

In recent practice, children and adolescents are educated in special classes in regular school or in inclusionary programs (in age appropriate regular classes, with additional supports as needed). In the United States, children with MR are now rarely if ever placed in residential institutions and separate schools. Adults with MR of all levels live in the community, in settings varying from their own

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apartments with supports as needed, to small shared living situations. They are employed in specialized settings or, increasingly, in the competitive job market. Habilitation and treatment include:

- Specific treatment of the underlying condition, if known, to prevent or to minimize brain insults that result in MR (e.g., shunting in the case of hydrocephalus).
- Early intervention, education, and ancillary therapies (such as physical, occupational, language therapies, *and behavior therapies*), family support, and other services, as needed.
- Treatment of comorbid physical conditions, such as hypothyroidism, congenital cataracts or heart defects in children with Down syndrome, treatment of seizures in persons with tuberous sclerosis, etc.
- Psychiatric treatment of comorbid mental disorders, including psychosocial interventions and pharmacotherapy.

Psychiatric Treatment

The approach to treatment of mental illness in persons with MR is generally the same as for persons without MR. Modifications of treatment may be necessary, according to the individual's circumstance. Persons with Down syndrome, e.g., may be exquisitely sensitive to anticholinergic drugs, and some persons with MR may be more sensitive to the disinhibiting effects of sedative/hypnotic agents.

Medical, habilitative, and educational interventions should be coordinated within an overall treatment program. Medication should be integrated as part of a comprehensive treatment plan that includes, appropriate behavior planning, behavior monitoring, and communication between the prescribing physician, therapists, and others providing supports, habilitative services, and general medical treatment.

Medication decisions should be appropriate to the diagnosis of record, based upon specific indications, and not made in lieu of other treatments or supports that the individual needs. There should be an effort, over time, to adjust medication doses to document ongoing need or the minimum dose at which a medication remains effective.

Medication decisions need to be based upon adequate information, including medication history and consideration of the individual's complete, current regimen. Medication decisions need to be made with due consideration for potential problems of polypharmacy, and otherwise for negative impact on the individual's functioning and overall quality of life. Every effort should be made to avoid unnecessary compromise of cognitive function or exacerbation of ataxia. Risk vs. benefit needs to be considered and continually reassessed, and justification should be provided, where the benefit of a medication comes with certain risks or negative consequences.

Behavioral Emergencies

- Restraint of any kind, where permitted, is used only when efforts at redirection have failed and the service recipient poses an imminent risk of harm to self or others.
- Emergency medications, where permitted, are given only after appropriate diagnostic assessment and other alternatives are contraindicated.

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- Possible medical causes for an acute behavioral exacerbation must be considered (e.g., other illness, injury, medication side effects)
- Reassessment of the diagnosis and the plan of treatment and support are indicated when there is an emergent behavioral episode

Psychotherapeutic Interventions

Psychotherapy can be effective for persons with MR, toward realization of a variety of goals:

- Mitigation of stressors
- Improved coping skills
- Improved communication of feelings, problems, etc.
- Improved problem solving skills
- Improved social and interpersonal skills
- Reduction/elimination of maladaptive behaviors
- Increase of adaptive behaviors
- Understanding of disability and illness
- Increased self-esteem

Modality and Technique

Group, individual, or family psychotherapy may be appropriate for persons with MR. As with psychiatric care, the approach to treatment of mental illness in persons with MR is generally the same as for persons without MR. Techniques typically utilized with persons with mental illness can be considered potential interventions for persons who are dually diagnosed, with adaptations made as necessary, based on the needs and strengths of the individual. The approach to therapy may need to be more concrete, repetitive, and/or directive, and may need to incorporate visual and auditory aids. Role play can be effective, and behavior modification techniques, such as positive reinforcement are very important.

Generally, the lower the cognitive and adaptive functioning of the person(s), the more extensive the modifications which will need to be made in technique. Some techniques are rarely appropriate for persons who function at the lower levels of mental retardation.

Group therapy in particular can be an invaluable treatment approach for a wide range of emotional, behavioral and life problems. Group therapy uses the power of group dynamics and peer interaction to promote learning and development of new skills among individual group members. Group therapy can be in promoting skills in decision making, problem solving, expression of feelings, socialization, communication, and in maintaining behavioral change.

Family therapy typically focuses on the parents' identification and support of their child's strengths and independence, and the provision of opportunities for success. Parents of recently diagnosed children need careful explanation of their child's condition. Concrete advice in management and resource finding is important, as well as help in obtaining educational supports to which the child is entitled under federal and local laws. Parents of adolescents and young adults need help in coming to terms with emergent sexuality, and in emotionally separating and preparing them to move to out-of-family living in the community.

Behavior Therapy is based upon scientific principles of behavior and uses a functional assessment to understand the variables that influence the behavior. Generally, to be effective, behavior therapy should

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Mental Retardation and Comorbid Disorders**

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be applied in all settings, and include an emphasis on increasing functional replacement skills, along with the reduction of the maladaptive behavior. This approach may include adjusting the environment to reduce physical and social conditions that seem to trigger maladaptive behaviors, and various specific techniques, such as systematic desensitization, progress relaxation, anger management, assertiveness training, and training more effective social and interactional skills.

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Conjoint Therapy with or without the child present may be used to address specific behavioral issues, and allows parents or caregivers to report their observations frankly. Parents or caregivers can be supported in their efforts at behavior management, which may otherwise tend to be transitory.

Treatment Follow-up

A common problem in the treatment of persons with MR is assessing its effectiveness, which may be viewed differently by various caregivers. Therefore, discrete treatment goals should be agreed upon by the clinician and caregivers, as well as target or "index" symptoms. Interdisciplinary collaboration of professionals and caregivers is essential. Various mental health clinicians might function in the team as direct care providers, team leaders, or consultants to other professionals. Among them, clinicians with medically and psychologically oriented training are often prepared to function as synthesizers of treatment modalities of various disciplines. Follow-up includes service recipient interview/observation and obtaining comprehensive interim information. If the service recipient is not experiencing improvement, the accuracy and completeness of the biopsychosocial diagnosis should be reviewed, as well as the consistency of implementation of treatment by the caregivers.

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TDMHDD Guideline
ADD/ADHD

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TDMHDD Guideline**PROTOCOL FOR THE EVALUATION AND TREATMENT OF
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER****INTRODUCTION**

The guidelines presented here are designed to assist in the evaluation and treatment of children between 5 and 12 years of age with "typical" ADHD in the primary care office. They are based on current understanding of the disorder and coordinate with recommendations from professional organizations, primarily the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry. The goal of the protocol is to improve the care of children with this disorder. It is not intended to dictate treatment decisions but to provide practitioners, especially those in primary care, with information and support as they care for children with ADHD. Complex cases, cases with significant co-morbidity or presentations outside the "typical" age range are beyond the scope of this protocol. Nonetheless the protocol may serve as a base for modifications in these complicated cases.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or otherwise from a legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age 16 or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

Tennessee law, effective March 1, 2000, permits a provider of routine health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. Acceptance of surrogate decision making is not mandatory, and is applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions,¹ because of mental retardation or developmental disability.²

Also effective March 1, 2000, Tennessee Code requires inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity. The committee may not, however, over-ride the decision of the recipient's guardian or conservator.³

¹ See TDMHDD Rule 0940.0000.

² Tennessee Code Annotated § 33-3-218 through 220.

³ Tennessee Code Annotated § 33-6-107 et seq.

TDMHDD Guideline
ADD/ADHD

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**IN A CHILD BETWEEN 5 AND 12 YEARS OLD WHO PRESENTS WITH
CHIEF COMPLAINT OF:**

School problems
Can't stay in seat
Difficulty taking turns
Can't follow instructions
Difficulty completing tasks
Interrupts, intrudes on others
Accident-prone
Difficulty being calm

Over active: fidgety restless
Easily distracted
Blurts out answers
Disruptive behavior
Talks excessively
Acts without thinking
Poor self esteem
"Someone thinks he has ADHD"

CONSIDER ADHD BY USING DSM IV CRITERIA:

CHECK ALL THAT APPLY:

At least 6 of the following symptoms of inattention have been present for at least 6 months *to a degree that is maladaptive and inconsistent with developmental level:*

- ☐ often fails to give close attention to details or makes careless mistakes in schoolwork
- ☐ often has difficulty in sustaining attention in tasks or play activities
- ☐ often does not seem to listen when spoken to directly
- ☐ often does not follow through on instructions and fails to finish schoolwork, chores (not due to oppositional behavior or failure to understand instructions)
- ☐ often has difficulty organizing tasks and activities
- ☐ often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (ex: schoolwork, homework)
- ☐ often loses things necessary for tasks or activities (toys, assignments, pencils, books)
- ☐ is often easily distracted by environmental stimuli
- ☐ is often forgetful in daily activities

OR

At least 6 of the following symptoms of hyperactivity and impulsivity have been present for at least 6 months *to a degree that is maladaptive and inconsistent with developmental level:*

- ☐ often fidgets with hands or feet or squirms in seat
- ☐ often leaves seat in classroom or in other situations in which remaining seated is expected
- ☐ often runs about or climbs excessively in situations in which it is inappropriate
- ☐ often has difficulty playing or engaging in leisure activities quietly
- ☐ is often "on the go" or often acts as if "driven by a motor"
- ☐ often talks excessively
- ☐ often blurts out answers before questions have been completed
- ☐ often has difficulty waiting turn
- ☐ often interrupts or intrudes on others (butts into conversations or games)

AND

☐ Some hyperactive, impulsive or inattentive symptoms *that caused impairment* were present before age 7 years

AND

☐ Some impairment from the symptoms is present in two or more settings (ex: school and home)

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AND

___ There is *clear evidence* of clinically significant impairment in social, academic or occupational functioning

AND

___ The symptoms do not occur only during a psychotic disorder or are not better accounted for by another mental disorder (ex: Mood Disorder, Anxiety Disorder, etc.)

CONFIRM DIAGNOSIS OF ADHD WITH DIRECT INFORMATION FROM PARENTS AND TEACHERS OR OTHER CAREGIVERS:

Request completion of ADHD-specific rating scales (ex.: Abbreviated Conners Scale) by parents and teachers.

Review school-based multidisciplinary evaluations or other school reports and assessments.

EVALUATE PRESENCE OF CO-MORBID CONDITIONS:

Learning Disabilities may exist where there is irregular achievement on school or when academic functioning is less than might be expected based on patient's overall intellect. Refer for psycho-educational testing to confirm.

Oppositional Defiant Disorder and **Conduct Disorder** may co-occur with ADHD in about 30% of patients. Hallmarks include high levels of defiance or other severely disruptive behavior beyond overactivity and poor attention skills. Consider consultation or referral to mental health care provider for diagnosis and treatment.

Anxiety Disorders with prominent worries, fears and tension may co-exist with ADHD. The restlessness and fidgetiness of Anxiety Disorders may resemble ADHD and should be considered in the differential diagnosis. Consider consultation or referral to mental health care provider.

Depressive Disorders may co-exist with ADHD, especially in patients who have experienced numerous failures or other stresses and have developed depressive thought patterns that begin to influence their outlooks. Some of these children may respond to support and experiencing success instead of failure. Others may require consultation or referral to mental health care provider.

Various **social stressors** including adjustment problems, family disruption or physical and sexual abuse can both co-exist and resemble the symptoms of ADHD. A careful and complete social history should be completed. Referral to mental health care providers or other agencies may be needed.

DISCUSS TREATMENT OPTIONS WITH PATIENT AND FAMILY:

Treatment should be **multi-dimensional** and include education, counseling, classroom/school modifications and medication depending on the specific needs of each individual child and family.

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The child and parents should be educated about the diagnosis and encouraged to understand this represents a challenge to overcome, not an "excuse" for misbehavior. Strengths and relative weaknesses should be identified. The variations in the presentation and the course of the disorder should be reviewed. Encouraging parents to become advocates for their child and informing them of their options is a part of education that may be done in the primary care office.

Various forms of counseling may be the major intervention for mild cases of ADHD. **Behavioral therapy** can be used to modify behavior using behavioral plans which target specific behavior, outline rewards and address how the plan is to be modified after success. **Family therapy** can be used to change family interactional patterns that may cause dysfunction and improve communication and other family functions to encourage the child with ADHD to rely upon his strengths. The family discipline system should be analyzed and modified in ways acceptable to all participants. Various forms of **individual counseling** may be indicated for children with problems coping or other co-morbid conditions. While general behavioral therapy may be done in the primary care office, other, more formal counseling and therapy, should be referred to a mental health care provider.

CONSIDER A TRIAL OF MEDICATION:**Plan A:**

Stimulant medications, either methylphenidate (Ritalin) or amphetamine (Dexedrine, Adderall), are first line medications in the treatment of ADHD. Discuss the indications, possible side effects (decreased appetite, sleep disturbance, headaches, moodiness) and an overall treatment plan with the parents. If consent is obtained begin treatment with low doses of stimulant medication in two to three daily divided doses, each about three to four hours apart (ex: 8AM, 12 N, 4PM).

Based on response and side effects, the dose can be adjusted fairly rapidly, once a week, to a maximum of 2mg/kg/day or 60mg/day of methylphenidate or 1mg/kg/day or 60mg/day of an amphetamine preparation. Most children with ADHD require doses less than the maximum. Lack of response to near maximum doses indicates a need to review the diagnosis and/or consideration of another medication.

Periodic follow up by phone calls and/or office visits should address response, compliance, side effects and overall functioning. Information for school staff is very useful in monitoring response to medications.

If a good response to first line stimulant is documented, changing to a long acting preparation of the same stimulant may be indicated for convenience and improved compliance.

Consideration should be given to "medication holidays", periods off medication. The indications for these are debatable. However, in consideration of parental desires, the severity of patient symptoms and the activities in which the child participates (ex: summer vacation may not be a good time for medication holiday for a child who is taking classes in summer school) medication-free periods may be desirable. Some knowledge about continued need for medication may be gained during these periods.

If poor response is seen to first line stimulant, go to Plan B.

Plan B:

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Lack of response to one stimulant does not indicate poor response to other stimulant medications. Therefore, start treatment with a second stimulant medication (amphetamine, if methylphenidate used in Plan A or vice versa). Methods of dosing and monitoring follow up are as in Plan A.

If poor response is seen, consider Plan C.

Plan C:

Consider treatment with pemoline (Cylert) a third available stimulant. Because of rare, fatal liver toxicity some clinicians may elect to bypass this step. Because of a longer half-life, once a day dosing is possible. Doses begin at 18.75 mg and may be increased in two to three weeks depending on response and side effects. Due to the longer half-life, response may take one to two weeks to occur. Frequent laboratory monitoring of hepatic enzymes (every two to three weeks) can be problematic and limits this option.

Plan D is considered by clinicians that opt against Plan C or for patients that do not respond to pemoline.

Plan D:

Tricyclic antidepressant medications have been shown to be useful in children with ADHD. Due to side effects, high overdose toxicity and poorer response rates than stimulants, these medications are thought of as third and fourth line medication interventions. Imipramine (Tofranil) is recommended. Due to possibly higher cardiac effects, desipramine (Norpramin) is not recommended. Pretreatment screening should include family history of cardiac arrhythmias, physical exam, general laboratory screens and an EKG. Side effects (sedation, increased appetite, tremors, and cardiovascular symptoms) are discussed with the patient and family. Dosing is started at 25 mg/day in once daily dosing.

The dose is gradually increased based on response and side effects. It may take one to two weeks to observe a clinical response, so dose should not be increased more frequently than weekly. Doses above 2-3mg/kg/day are associated with increased adverse events. Doses higher than this merit reconsideration of the diagnosis and consultation with specialists.

Response, including reports for school staff, should be monitored along with occurrence of side effects and overall functioning. EKG should be monitored throughout treatment, especially at increased doses.

**CONSIDER REFERRAL TO SPECIALIST IN DEVELOPEMETNAL PEDIATRICS
OR CHILD PSYCHAITRY:**

Using these guidelines it is estimated that about 90% of children with ADHD will show significant response in the primary care setting (in conjunction with educational and counseling interventions). Lack of response to these interventions indicates need for re-evaluation and possible referral to specialist in developmental pediatrics or child psychiatry.

Attachment J

Semiannual Review of Appeals



STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TennCare
OFFICE OF GENERAL COUNSEL

Don Sundquist
Governor

Doctor's Building, 5th Floor
706 Church Street
Nashville, Tennessee 37247-0064
(615) 741-1354 / FAX (615) 532-7322

C. Warren Neel
Commissioner

Memorandum

TO: Linda Ross
Attorney General's Office

FROM: Betty F. Boner *BFB*
Deputy General Counsel

DATE: July 18, 2001

SUBJECT: EPSDT REPORT (January-June 2001)

The number of appeals reflected may not include all appeals received during this time period, as these numbers are dependent on the data pulls. Data for this report was pulled July 7, 2001.

For each MCO/BHO, the table below reflects the total number of children's appeals for January - June 2001.

MCO/BHO	January - June 2001 TOTAL # OF CHILDREN'S APPEALS
Access MedPlus	2392
DMR	30
John Deere	150
OmniCare	273
PHP	380
Prudential	3
TLC	447
VHP	49
VSHP	3699
Xantus	985
Other	7
TOTAL	8415
Premier	415
TBH	175
TOTAL	590
GRAND TOTAL	9005

Based on a compilation of Service appeals data for January-June 2001, there were a total of 9005 appeals filed on behalf of children (under 21 years of age). Eight thousand two hundred five (8205) were regular appeals and eight hundred (800) were expedited appeals. As of July 7, 2001 four thousand six hundred sixty-three (4663) of these appeals are still pending a final resolution.

CARE TYPES

Children's appeals included 31 service types. The Service Types with the highest number of appeals are: Pharmacy (2193), Reimbursement (492), Access to Service (430), Other (313), Dental (258), Residential Treatment – Child (221), and Physician (100),

Additional Care Types include: Procedure (59), DME (55), MH-Inpatient (55), Eligibility (22), MR Waiver (21), Home Health (19), A&D (19), Therapeutic Foster Care (17), MH-Outpatient (13), Vision (9), Independent Living (7), Psychiatric Evaluation (7), Physical Therapy (6), Occupational Therapy (5), Speech Therapy (4), Methadone Treatment (3), Transportation (3), Hospital (2), Rehabilitation (2), Emergency (2), Drug Approval (1), Nutritional (1), Service (1), and Quality (1).

TYPE OF SERVICE, MCO/BHO

MCO/BHO NAME	TYPE OF SERVICE
Access Med Plus	Pending (1106), Pharmacy (679), Access to Services (248), Dental (122), Reimbursement (105), Other (71), Physician (35), Procedure (6), Vision (5), Eligibility (4), DME (4), Home Health (3), Occupational Therapy (1), Physical Therapy (2), Speech Therapy (1)
Department of Mental Retardation	MR Waiver (21), Pending (9).
John Deere	Pending (68), Pharmacy (24), Reimbursement (17), Access to Services (16), Other (13), DME (3), Dental (2), Home Health (2), Procedure (2), Drug Approval (1), Eligibility (1), Physical Therapy (1).
Omni Care	Pending (120), Pharmacy (96), Other (22), Reimbursement (11), Dental (7), Access to Services (5), Procedure (5), Physician (3), Eligibility (2), Home Health (1), DME (1).
Prudential	Reimbursement (2), Pending (1).
TLC Family Care Health Plan	Pending (206), Pharmacy (155), Reimbursement (28), Other (28), Dental (18), DME (4), Home Health (2), Access to Services (2), Physician (2), Eligibility (1), Physical Therapy (1).
VHP Community Care	Pending (30), Reimbursement (5), Other (5), Pharmacy (5), Access to Services (2), Dental (1), Vision (1).
VSHP	Pending (2343), Pharmacy (789), Reimbursement (206), Access to Services (111), Other (85), Dental (54), Procedure (40), DME (28), Physician (20), Eligibility (9), Home Health (7), Physical

VSHP Cont.	Therapy (2), Emergency (1), Nutritional (1), Service (1), Occupational Therapy (1), Quality (1).
Xantus	Pending (430), Pharmacy (336), Reimbursement (54), Dental (44), Physician (38), Other (35), Access to Services (21), DME (12), Vision (3), Occupational Therapy (3), Speech Therapy (3), MH-Inpatient (2), Eligibility (1), Home Health (1), Procedure (1), Rehabilitation (1).
Other	Eligibility (3), Reimbursement (2), Pending (2).
Premier	Residential Treatment (155), Pending (114), MH-Inpatient (39), Other (20), Pharmacy (13), A&D (13), Therapeutic Foster Care (13), Reimbursement (12), MH-Outpatient (11), Psychiatric Evaluation (6), Independent Living (5), Access to Services (4), Transportation (3), Home Health (2), Hospital Inpatient (2), Eligibility (1), Emergency Services (1), Provider Payments (1).
TBH	Residential Treatment (66), Pending (41), Other (20), MH-Inpatient (14), Reimbursement (6), A&D (6), Access to Services (5), Pharmacy (5), Therapeutic Foster Care (4), Methadone Treatment (3), Independent Living (2), MH-Outpatient (2), Psychiatric Evaluation (1).

APPEALS RESOLUTIONS

MCO/BHO DECISION	TOTAL	APPEAL UNIT DECISION	TOTAL
Affirmed	5741	Affirmed	95
		Case Withdrawn by Enrollee	30
		Informal Resolution	339
		Reversed	500
		Pending	4661
		Directive Issued	81
		Transferred	33
		Cont. By Petitioner	2
Total	5741	Total	5741
Case withdrawn by enrollee	20	No Decision Required	20
Informal Resolution by Agreement	769	No Decision Required	769
Reversed	2435	No Decision Required	2435
Service Approved	40	No Decision Required	40
Grand Total	9005	Grand Total	9005

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TDMHDD Guideline
Anxiety Disorders

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TDMHDD Guideline

Anxiety Disorders in Children and Adolescents

Introduction

The guidelines presented here are designed to assist in the evaluation and treatment of children and adolescents with anxiety disorders in the primary care setting. These guidelines are based on the following source material:

Practice parameters for the assessment and treatment of children and adolescents with anxiety disorders. J Am Acad Child Adolesc Psychiatry 1997 Oct;36(10 Suppl):69S-84S
[161 references]

The user may wish to refer to the source material for complete text, annotations, and references.

The goal of this protocol is to improve the care of children/adolescents with conduct disorder and aid practitioners in diagnosis and treatment selection.

These guidelines are not intended to define or serve as a standard of medical care.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or otherwise from a legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age 16 or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

Tennessee law, effective March 1, 2000, permits a provider of routine health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. Acceptance of surrogate decision making is not mandatory, and is applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions,¹ because of mental retardation or developmental disability.²

Also effective March 1, 2000, Tennessee Code requires inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity. The committee may not, however, over-ride the decision of the recipient's guardian or conservator.³

1. See TDMHDD Rule 0940 xxxx

2. Tennessee Code Annotated § 33-3-218 through 220

3. Tennessee Code Annotated § 33-6-107 et seq.

TDMHDD Guideline
Anxiety Disorders

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Differential Diagnosis

Hypoglycemic episodes	Medication reaction: antihistamines,
Hyperthyroidism	antiasthmatics, sympathomimetics,
Cardiac arrhythmias	steroids, haloperidol, pimozide, SSRIs,
Caffeinism	antipsychotics, OTC's (diet pills, cold
Pheochromocytoma	medicines, etc.)
Seizure disorders	Mood disorders
Migraine	ADHD
CNS disorders- delirium, brain tumor	Substance abuse disorders
Personality disorders	Eating disorders
Pervasive developmental disorders	Schizophrenia

DSM-IV Criteria

Generalized Anxiety Disorder

1. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
2. The person finds it difficult to control the worry.
3. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months).

Note: Only one item is required in children.

1. restlessness or feeling keyed up or on edge
 2. being easily fatigued
 3. difficulty concentrating or mind going blank
 4. irritability
 5. muscle tension
 6. sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
4. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.
 5. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
 6. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

**TDMHDD Guideline
Anxiety Disorders**

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Social Phobia**

- A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. Note: In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.
- B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed Panic Attack. Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.
- C. The person recognizes that the fear is excessive or unreasonable. Note: In children, this feature may be absent.
- D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress.
- E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
- F. In individuals under age 18 years, the duration is at least 6 months.
- G. The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., Panic Disorder With or Without Agoraphobia, Separation Anxiety Disorder, Body Dysmorphic Disorder, a Pervasive Developmental Disorder, or Schizoid Personality Disorder).
- H. If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it, e.g., the fear is not of Stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in Anorexia Nervosa or Bulimia Nervosa.

Panic Disorder

- A. A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:
 - 1. palpitations, pounding heart, or accelerated heart rate
 - 2. sweating
 - 3. trembling or shaking
 - 4. sensations of shortness of breath or smothering
 - 5. feeling of choking
 - 6. chest pain or discomfort
 - 7. nausea or abdominal distress
 - 8. feeling dizzy, unsteady, lightheaded, or faint
 - 9. derealization (feelings of unreality) or depersonalization (being detached from oneself)
 - 10. fear of losing control or going crazy
 - 11. fear of dying
 - 12. paresthesias (numbness or tingling sensations)
 - 13. chills or hot flushes
- B. At least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:
 - 1. persistent concern about having additional attacks
 - 2. worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy")
 - 3. a significant change in behavior related to the attacks
- C. The Panic Attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).

**TDMHDD Guideline
Anxiety Disorders**

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- D. The Panic Attacks are not better accounted for by another mental disorder, such as Social Phobia (e.g., occurring on exposure to feared social situations), Specific Phobia (e.g., on exposure to a specific phobic situation), Obsessive-Compulsive Disorder (e.g., on exposure to dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., in response to stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., in response to being away from home or close relatives).

Obsessive-Compulsive Disorder

A. Either obsessions or compulsions:

Obsessions as defined by (1), (2), (3), and (4):

1. recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress
2. the thoughts, impulses, or images are not simply excessive worries about real-life problems
3. the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action
4. the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

Compulsions as defined by (1) and (2):

1. repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly
 2. the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive
- B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. **Note:** This does not apply to children.
- C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.
- D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).
- E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Posttraumatic stress disorder- *(see full guideline in this manual for additional information)*

- A. The person has been exposed to a traumatic event in which both of the following were present:
1. the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
 2. the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior
- B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
 2. recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
 3. acting or feeling as if the traumatic event were recurring (includes a sense of reliving the

**TDMHDD Guideline
Anxiety Disorders**

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- experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur
- 4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- 5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
 - 1. efforts to avoid thoughts, feelings, or conversations associated with the trauma
 - 2. efforts to avoid activities, places, or people that arouse recollections of the trauma
 - 3. inability to recall an important aspect of the trauma
 - 4. markedly diminished interest or participation in significant activities
 - 5. feeling of detachment or estrangement from others
 - 6. restricted range of affect (e.g., unable to have loving feelings)
 - 7. sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
 - 1. difficulty falling or staying asleep
 - 2. irritability or outbursts of anger
 - 3. difficulty concentrating
 - 4. hypervigilance
 - 5. exaggerated startle response
- E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Other phobias

- A. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).
- B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed Panic Attack. **Note:** In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging.
- C. The person recognizes that the fear is excessive or unreasonable. **Note:** In children, this feature may be absent.
- D. The phobic situation(s) is avoided or else is endured with intense anxiety or distress.
- E. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
- F. In individuals under age 18 years, the duration is at least 6 months.
- G. The anxiety, Panic Attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as Obsessive-Compulsive Disorder (e.g., fear of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor), Separation Anxiety Disorder (e.g., avoidance of school), Social Phobia (e.g., avoidance of social situations because of fear of embarrassment), Panic Disorder With Agoraphobia, or Agoraphobia Without History of Panic Disorder

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Anxiety Disorders

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Separation anxiety

- A. Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three (or more) of the following:
 - 1. recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated
 - 2. persistent and excessive worry about losing, or about possible harm befalling, major attachment figures
 - 3. persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)
 - 4. persistent reluctance or refusal to go to school or elsewhere because of fear of separation
 - 5. persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings
 - 6. persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
 - 7. repeated nightmares involving the theme of separation
 - 8. repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated
- B. The duration of the disturbance is at least 4 weeks.
- C. The onset is before age 18 years.
- D. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.
- E. The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and, in adolescents and adults, is not better accounted for by Panic Disorder With Agoraphobia.

Behavioral Treatment

Behavioral therapy targets the patient's overt behavior and emphasizes treatment within the context of family and school instead of focusing on the etiology of the behavior.

Cognitive-behavioral treatment integrates a behavioral approach with an emphasis on changing the cognitions associated with the patient's anxiety.

Psychodynamic psychotherapy includes a greater participation of the parents/caregivers and a more explicit use of active support, practical guidance, and environmental interventions.

Parent-child interventions may include helping parents/caregivers encourage children/adolescents to face new situations rather than withdrawing, refraining from excessive criticism and intrusiveness, responding to children's needs, and encouraging children to engage in activities despite anxiety. Infant-parent psychotherapy is recommended where there are attachment problems.

Family therapy is also used to disrupt the dysfunctional family interactional patterns that promote family insecurity and to support areas of family competence.

Psychoeducation is important in treatment of panic disorder.

Pharmacological Treatment

Pharmacotherapy should never be used as the sole intervention. Pharmacotherapy should be used only as an adjunct to behavioral or psychotherapeutic interventions. Selection of the appropriate medication is primarily based on comorbid conditions if they exist. For a child/adolescent with ADHD or enuresis, a tricyclic antidepressant is the drug of choice. A child with comorbid obsessive-compulsive disorder would benefit the most from an SSRI. Side effect profile should also be considered when selecting medication therapy.

Benzodiazepines are often used on a short-term basis, and in the case of severe anxiety.

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Anxiety Disorders**

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benzodiazepines may be used in conjunction with an SSRI or TCA for several weeks until the antidepressant begins to show beneficial effects.

Treatment Steps

1. Determine onset and development of symptoms and the context in which the symptoms occur and are maintained.
 - a. Is anxiety stimulus specific, spontaneous, or anticipatory?
 - b. Is avoidant behavior present?
 - c. Do comorbid symptoms exist?
2. Explore patient's development history including temperament, ability to soothe self or be soothed, quality of attachment, adaptability, stranger and separation responses, childhood fears.
3. Obtain medical history, medication history, school history, social history, and family history.
4. Interview patient and conduct a mental status exam.
5. Conduct family assessment and parent-child relationship.
6. Refer for IQ, psychological, learning disability, and speech and language testing if indicated.
7. Establish diagnosis
 - a. Consider physical conditions that may mimic anxiety disorders.
 - b. Screen for psychiatric disorders that may be comorbid with or misdiagnosed as anxiety disorders.
 - c. Consider that more than one anxiety disorder may be present.
8. Education of parents and other significant persons about symptoms, clinical course, treatment options, and prognosis.
9. Consult and collaborate with school personnel.
10. Begin behavioral or psychotherapy depending on the diagnosis.
 - a. separation anxiety disorder-
 - behavioral program involving child/adolescent, parents, school personnel, and other appropriate persons
 - family interventions including family therapy, parent-child interventions, and parental guidance
 - psychotherapy including cognitive-behavioral therapy and psychodynamic psychotherapy
 - b. other anxiety disorders-
 - psychotherapy including cognitive-behavioral and behavioral therapy techniques
 - psychodynamic psychotherapy
 - family interventions
 - c. social phobia-
 - cognitive-behavioral therapy and behavioral therapy
 - individual or group psychotherapy
 - family intervention
 - d. other phobias-
 - behavioral and cognitive-behavioral therapy
 - complicated cases may require individual and group psychotherapy
 - e. panic disorder-
 - cognitive-behavioral therapy
 - individual psychodynamic, group, or family psychotherapies

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- f. obsessive-compulsive disorder-
 - cognitive-behavioral therapy
 - therapist-assisted exposure and response prevention
 - g. posttraumatic stress disorder-
 - cognitive-behavioral therapy
 - exposure therapy
 - psychodynamic psychotherapy
 - family therapy
 - discussion groups or peer counseling groups
11. Begin pharmacotherapy depending on the diagnosis and severity.
- a. separation anxiety disorder- in severe cases use a benzodiazepine +/- TCA* or SSRI
 - b. other anxiety disorders- in severe cases use a benzodiazepine +/- TCA* or SSRI
 - c. social phobia- SSRI
 - d. other phobias- pharmacotherapy rarely used
 - e. panic disorder- SSRI or TCA +/- benzodiazepine
 - f. obsessive-compulsive disorder- SSRI or clomipramine
 - g. posttraumatic stress disorder- antidepressant of choice

*Trazodone is often effective in these cases

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TDMHDD Guideline
Conduct Disorder

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TDMHDD GUIDELINE**Evaluation and Treatment
of Conduct Disorder in Children and Adolescents****Introduction**

The guideline presented here is designed to assist in the evaluation and treatment of children and adolescents with conduct disorder in primary care and behavioral treatment settings. Portions of this guideline are based the following sources:

Practice parameters for the assessment and treatment of children and adolescents with conduct disorder. J Am Acad Child Adolesc Psychiatry 1997 Oct;36(10 Suppl):122S-139S [225 references]

Decision trees and essential outline materials were furnished by Martha Wike, Ph.D., Consulting Psychologist, Tennessee Department of Children's Services

The goal of this protocol is to improve the care of children/adolescents with conduct disorder and aid practitioners in diagnosis and treatment selection.

These guidelines are not intended to define or serve as a standard of medical care.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or otherwise from a legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age 16 or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

Tennessee law, effective March 1, 2000, permits a provider of routine health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. Acceptance of surrogate decision making is not mandatory, and is applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions.¹ because of mental retardation or developmental disability.²

Also effective March 1, 2000, Tennessee Code requires inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity. The committee may not, however, over-ride the decision of the recipient's guardian or conservator.³

1. See TDMHDD Rule 0940 xxxx

2. Tennessee Code Annotated § 33-3-218 through 220

3. Tennessee Code Annotated § 33-6-107 et seq

TDMHDD Guideline Conduct Disorder

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Differential Diagnosis

Oppositional defiant disorder	Adjustment disorder
ADHD	Mood disorders
Substance abuse	Child or adolescent antisocial behavior
Medical disorders	Personality disorders
PTSD	Schizophrenia
Developmental disorders	

DSM-IV Criteria

Conduct Disorder, as defined by the DSM-IV, consists of a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:

- Must have 3 or more:
 - Aggression to people or animals
 - Destruction of property
 - Deceitfulness or theft
 - Serious violation of rules
 - In the past 12 months
 - With at least 1 in the past 3 months
- The disturbance in behavior causes clinically significant impairment
- If 18 or older, not Antisocial Personality

Assessment

- Patient interview (with and without parents)...assess mental status, impulse control, capacity for attachment, trust and empathy, tolerance for negative emotions
- Parent interview...assess developmental hx, family hx of mood and thought disorders, impulse control and substance abuse disorders, personality disorders
- Collateral contact interviews (school, court)
- Physical exam, including urine or blood drug screen, if drug use is suspected

Treatment

Treatment should be provided in a continuum of care that allows flexible application of modalities by a cohesive treatment team. Outpatient treatment of conduct disorder includes intervention in the family, school, and peer group.

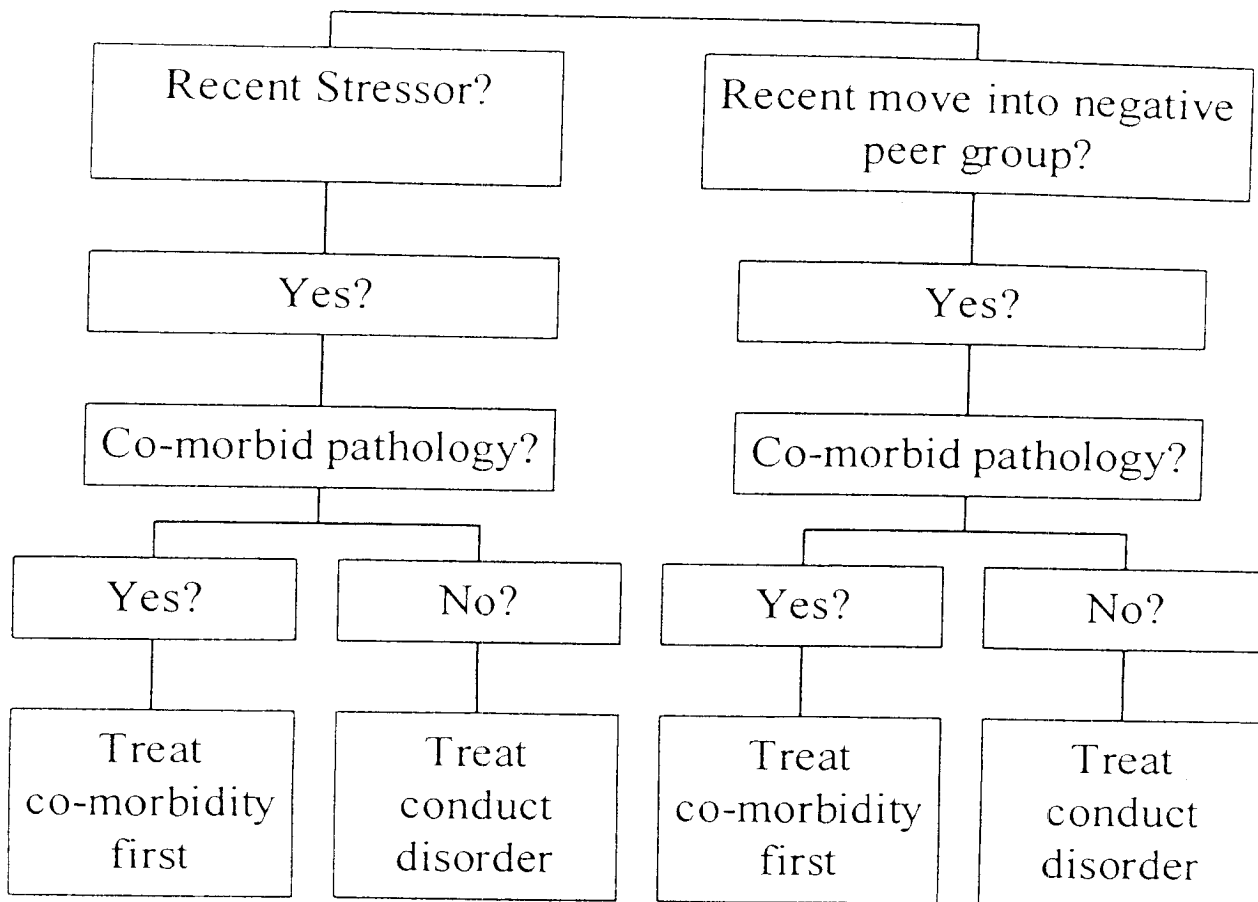
- Treat comorbid disorder

TDMHDD Guideline
Conduct Disorder

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- *Family interventions* include parent guidance, skills training and family therapy.
 - Work on parenting strengths...eliminate too harsh and too permissive approaches
 - Treat parental pathology
- *Individual and group psychotherapy* with adolescent or child. The technique of intervention should be adapted to child's age, processing style, and ability to engage in treatment.
 - Group therapy is important with adolescents.
 - Individual therapy, alone, is ineffective
- *Psychosocial skill-building training.*
 - Child training to improve peer relationships
 - Child training to improve academic skills
 - Child training to improve compliance with demands from authority figures
 - Social skills building
- *Other psychosocial interventions* should be considered as indicated. Some interventions to consider are peer intervention, school intervention for appropriate placement, juvenile justice system intervention, social services, community resources, out-of-home placement, and job and independent-living skills training.
- *Psychopharmacology.* Medications are recommended only for treatment of target symptoms and comorbid disorders and are recommended only on the basis of clinical experience.
- *Level of care decision-making.* Level of care should be the least restrictive level of intervention that fulfills both the short and long-term needs of the patient.

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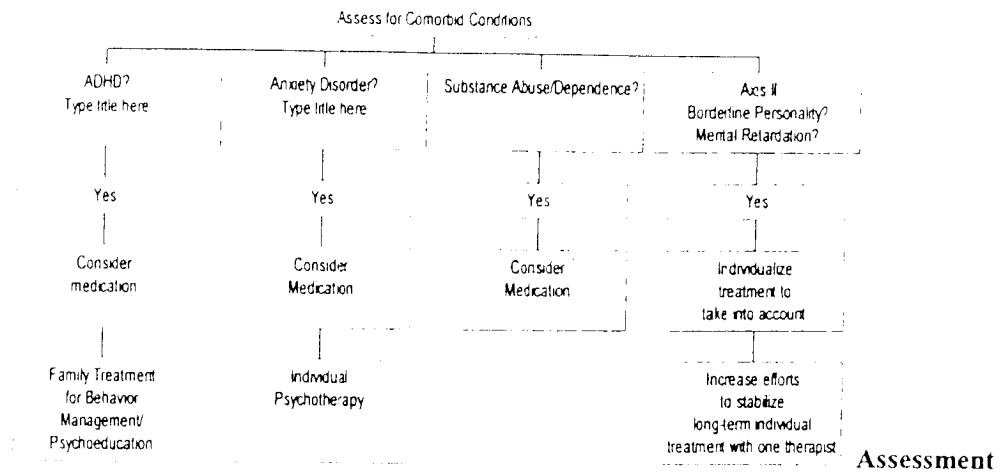
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Conduct Disorder

Decision Tree for Conduct Disorder

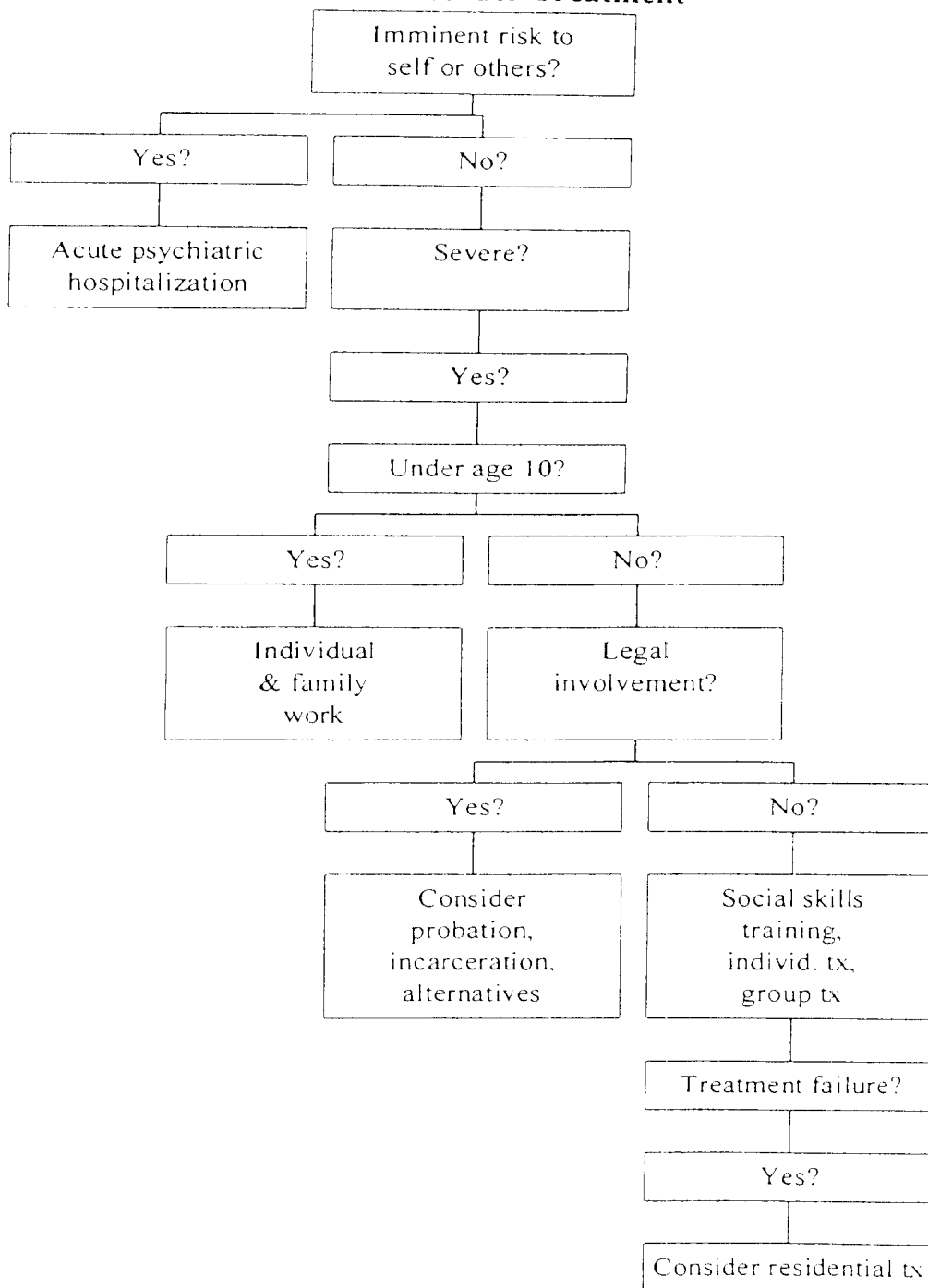
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Conduct Disorder**Conduct Disorder Treatment**

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TDMHDD Guideline
Depression

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TDMHDD GUIDELINE

Depression in Children and Adolescents

Introduction

The guidelines presented here are designed to assist in the evaluation and treatment of children and adolescents with depressive disorders in the primary care setting. These guidelines are adapted from:

Practice parameters for the assessment and treatment of children and adolescents with depressive disorders. J Am Acad Child Adolesc Psychiatry 1998 Oct;37(10 Suppl):63S-83S [231 references]

The user may wish to consult the source material for complete texts, annotations, and references.

The goal of this protocol is to improve the care of children/adolescents with depression and aid practitioners in diagnosis and treatment selection.

These guidelines are not intended to define or serve as a standard of medical care.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or otherwise from a legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age 16 or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

Tennessee law, effective March 1, 2000, permits a provider of routine health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. Acceptance of surrogate decision making is not mandatory, and is applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions,¹ because of mental retardation or developmental disability.²

Also effective March 1, 2000, Tennessee Code requires inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity. The committee may not, however, over-ride the decision of the recipient's guardian or conservator.³

1. See TDMHDD Rule 0940 xxxx

2. Tennessee Code Annotated § 13-3-218 through 220

3. Tennessee Code Annotated § 13-6-107 et seq.

Assessment

- Comprehensive psychiatric diagnostic evaluation, including interviews with the child, parents, and collateral informants, such as teachers and social services personnel,
- Evaluation performed by a clinician trained to consider how developmental and cultural factors impact the patient's clinical presentation.
- Performance of a developmentally appropriate mental status examination (MSE), physical examination, laboratory tests
- Assessment of risk for suicidal behaviors

TDMHDD Guideline Depression

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- Global functioning assessment using scales such as the Children's Global Assessment Scale or the Global Assessment of Functioning.
- Identification of other pertinent issues that will require ongoing treatment (family dysfunction, school difficulties, comorbid disorders)
- Ongoing assessment

Differential Diagnosis

Anxiety disorders
Learning disabilities
Disruptive disorders
ADHD
Substance abuse
Personality disorder
Medical disorders

Adjustment disorder
Chronic fatigue syndrome
Bereavement
Anorexia nervosa
Premenstrual dysphoric disorder
Bipolar disorder
Eating disorders

DSM-IV Criteria for Major Depressive Disorder

Major Depressive Disorder (MDD), in general consists of:

- One or more Major Depressive Episodes, as defined below,
- Not better accounted for by Schizoaffective Disorder, and not superimposed on Schizophrenia, Schizophreniform, Delusional, or Psychotic Disorder, **and**

There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode (except as may have been induced by substance, treatment, or due to the direct physiological effect of a general medical condition)

A Major Depressive Episode, as defined by the DSM-IV, consists of either a depressed or irritable mood and/or a loss of interest or pleasure for at least 2 weeks, in addition to the presentation of 5 or more of the following symptoms:

- | | |
|--|---|
| <ul style="list-style-type: none"> • DEPRESSED MOOD MOST OF THE DAY, NEARLY EVERY DAY • mARKEDLY DIMINISHED INTEREST IN ACTIVITIES, MOST OF THE DAY, NEARLY EVERY DAY • sIGNIFICANT Weight loss/weight gain • Insomnia/hypersomnia | <ul style="list-style-type: none"> • Psychomotor retardation OR agitation • Decreased energy or motivation • Guilt feelings • Inability to concentrate • rECURRENT Thoughts of DEATH OR suicidal IDEATION, sUICIDE ATTEMPT OR PLAN |
|--|---|

TDMHDD Guideline
Depression

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AND these symptoms:

<ul style="list-style-type: none"> • Social impairment or impairment in performance of activities • Unrelated to substance abuse 	<ul style="list-style-type: none"> • Unrelated to bereavement • Unrelated to medication use or other psychiatric illness
--	--

Treatment

Treatment Planning

- Develop treatment plan appropriate to developmental stage of child or adolescent
- Provide services in the least restrictive environment that provides safety and effectiveness

Acute Treatment

- The choice of initial therapy depends on
 - ♦ Chronicity
 - ♦ Severity and number of prior episodes
 - ♦ Contextual issues
 - ♦ Previous response to treatment
 - ♦ Age of patient
 - ♦ Compliance with treatment
 - ♦ Patient's and family's motivation for treatment
- Pharmacotherapy alone usually is not sufficient.
- The high degree of comorbidity and the severity of psychosocial and academic consequences of depression suggest a multi-modal treatment approach.
- Because depression usually runs in families it is important to assess and treat other family members and those who live with the patient.

Patient and Family Education

The patient and caregivers should be taught about the disease and the treatment involved. Family education involves them as informed partners in the treatment team, and helps them understand depression as an illness, identify and manage affect, address psychosocial deficits, and learn the importance of compliance with treatment. Participation by parents may help them identify their own depressive symptoms.

Psychotherapy

- *Psychodynamic psychotherapy* can help youth understand themselves, identify feelings, improve self-esteem, change maladaptive patterns of behavior, interact more effectively with others, and cope with ongoing and past conflicts.
- *CBT* is based on the premise that depressed patients have cognitive distortions in how they view themselves, the world, and the future; that these cognitive distortions contribute to their depression. CBT teaches patients to identify and counteract these distortions. Clinical studies found a high rate of relapse upon follow-up, suggesting the need for continuation treatment

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Depression

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- *IPT* focuses on problem areas of grief, interpersonal roles, disputes, role transitions, and personal difficulties. *IPT* has been shown to be useful in the acute treatment of adolescents with MDD. The rate of relapse may be relatively low after acute *IPT* treatment

Antidepressant Medication

Pharmacotherapy alone is never sufficient as the sole treatment. Combined treatment promotes self-esteem, coping skills, adaptive strategies, and improved peer and family relationships.

Antidepressant medications seem indicated for children and adolescents with severe symptoms that prevent effective psychotherapy; whose symptoms fail to respond to an adequate trial of psychotherapy; with chronic or recurrent depression; and with psychotic or bipolar depressions.

Prior to initiating treatment, specific target symptoms should be defined with the patient and parents. They should be informed about side effects, dose schedule, the lag in onset of therapeutic effect, and the danger of overdose. Parents should maintain responsibility for storing and administering the medications to enhance compliance and minimize suicidal risk from overdose. Quantity of dispensed medications should be monitored carefully.

Selective serotonin reuptake inhibitors (SSRIs) are the initial antidepressants of choice for patients requiring pharmacotherapy, although the presence of comorbidities may require alternate initial agents or a combination of medications. There is no indication for laboratory tests before or during the administration of SSRIs.

SSRIs (Prozac, Zoloft, Paxil, and Celexa) are the drugs of choice because of their safety, side effect profile, ease of use, and suitability for long-term maintenance. Since improvement with the SSRIs may take 4 to 6 weeks, patients should be treated with adequate and tolerable doses for at least 4 weeks. At 4 weeks, if patients have not shown even minimal improvement, treatment should be modified (e.g., increase dose, change medications). If the patient shows improvement at 4 weeks, the dose should be continued for at least 6 weeks. The SSRIs have a relatively flat dose-response curve, suggesting that maximal clinical response may be achieved at minimum effective doses.

Tricyclic Antidepressants are not recommended as first line treatment for youth with depressive disorders because of the lack of efficacy and potential side effects. Nevertheless, individual patients may respond better to the TCAs than other medications. If Tricyclic Antidepressants (TCAs) are used, baseline electrocardiogram (EKG), resting blood pressure and pulse (supine or sitting, standing), and weight should be monitored regularly.

Augmentation agents may be indicated for children who are resistant to treatment or present complicating factors. Such agents may include:

- Trazodone
- Anticonvulsants
- Antimania medication
- ECT (only as authorized by statute. See T.C.A. 33-8-301 et seq.)
- Antipsychotic medication (for MDD with psychotic features)*

* See guideline on treatment of Schizophrenia for additional information on antipsychotic medication

**TDMHDD Guideline
Depression****DRAFT COPY***Continuation Phase*

- Continuation therapy is recommended for all patients for at least 6 months after remission.
- The patient and his or her family should be taught to recognize early signs of relapse.
- Continuation psychotherapy helps to foster medication compliance.
- Antidepressants must be continued at the same dose used to attain remission of acute symptoms.
- At the end of the continuation phase, for patients who do not require maintenance treatment, medications should be discontinued gradually.

Maintenance Therapy

Clinicians should consider maintenance therapy for patients with multiple or severe episodes of depression and those at high risk for recurrence. Factors associated with recurrence include a family history of bipolar disorder or recurrent depression, comorbid psychiatric disorders, stressful or non-supportive environments, and residual or subsyndromal symptomatology.

The treatments that were used to induce remission in the acute phase should be used for maintenance therapy. Youth with two or more episodes of depression should receive maintenance treatment for at least 1 to 3 years. Patients with recurrent episodes accompanied by psychosis, severe impairment, severe suicidality, and treatment-resistance, as well as patients with more than 3 episodes, should be considered for longer, even lifelong treatment.

The long-term effects of antidepressants on maturation and development of children have not been studied. The clinician and patient's family should therefore weigh the risks and benefits of pharmacotherapy in maintenance therapy.

DYSTHYMIC DISORDER**DSM-IV Criteria for Dysthymic Disorder (child or adolescent)**

- Depressed Mood, most of the day, more days than not, for at least one year
- Presence, while depressed, of two or more of the following
 - ♦ poor appetite or overeating
 - ♦ low energy or fatigue
 - ♦ low self-esteem
 - ♦ poor concentration or difficulty making decisions
 - ♦ feelings of hopelessness
- The foregoing symptoms have not abated for more than 2 months at a time during the year
- The disturbance is not better accounted for by MDD
- There has never been a manic, mixed, or hypomanic episode
- The disturbance does not occur exclusively in the course of a Psychotic Disorder
- The symptoms are not due to physiological effects of substance use or a general medical condition
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

**TDMHDD Guideline
Depression****DRAFT COPY****Treatment**

Clinical practice and theory support the use of psychotherapies of varying degrees of intensity, including psychoanalysis, psychodynamic psychotherapy, CBT, and IPT, to treat DD. In the absence of published studies of psychotherapeutic or pharmacologic treatment of children and adolescents with DD or comorbid MDD and DD, clinicians are advised to use interventions recommended for the treatment of youth with MDD.

PREVENTION

Youth with subclinical depressive symptoms are at high risk to develop clinical depression. When these symptoms persist after an episode of depression continuous treatment until full remission is recommended. For patients who have not had an episode of depression, psychosocial interventions to reduce environmental and family stressors and CBT strategies appear to be efficacious to prevent deterioration.

Children with DD usually have a first episode of MDD 2 to 3 years after the onset of the DD, suggesting that DD is a gateway to recurrent mood disorders and indicating the need for early intervention with mild to moderate depression. Early intervention with depressed youth also may avert the development of comorbid psychiatric disorders. For example, MDD often precedes the onset of substance use disorders and treatment of depression may prevent their development.

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TDMHDD Guideline
Mental Retardation and Comorbid Disorders

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TDMHDD Guideline**Mental Retardation and Comorbid Disorders
in Adults over 22 Years of Age****Introduction**

The guidelines presented here are designed to assist in the evaluation and treatment of children and adolescents who have mental disorders comorbid with mental retardation. These guidelines are adapted from the following sources:

Practice parameters for the assessment and treatment of children, adolescents, and adults with mental retardation and comorbid mental disorders. J Am Acad Child Adolesc Psychiatry 1999 Dec;38(12 Suppl):5S-31S [117 references]

Rush AJ, & Frances A., eds. *The Expert Consensus Guideline Series: Treatment of Psychiatric and Behavioral Problems in Mental Retardation.* American Journal on Mental Retardation 2000;105:159-228.

The user may wish to refer to the source material for complete text, annotations, and references

Goals of this Protocol:

1. To improve the care of children/adolescents, and young adults up to 21 to 22 years of age (an upper age limit of eligibility for public special education and related services in some states), who present mental retardation and possible comorbid disorders.
2. To aid practitioners in the difficult task of assessment and then choosing the correct treatment for each individual child. These guidelines are not intended to define or serve as a standard of medical care. Clinical management recommendations herein do not replace clinical judgement, tailored to the particular needs of each clinical situation.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or otherwise from a legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age 16 or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

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TDMHDD Guideline
Mental Retardation and Comorbid DisordersTDMHDD Guideline**Mental Retardation and Comorbid Disorders
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The user may wish to refer to the source material for complete text, annotations, and references

Goals of this Protocol:

1. To improve the care of children/adolescents, and young adults up to 21 to 22 years of age (an upper age limit of eligibility for public special education and related services in some states), who present mental retardation and possible comorbid disorders.
2. To aid practitioners in the difficult task of assessment and then choosing the correct treatment for each individual child. These guidelines are not intended to define or serve as a standard of medical care. Clinical management recommendations herein do not replace clinical judgement, tailored to the particular needs of each clinical situation.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or otherwise from a legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age 16 or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

Tennessee law, effective March 1, 2000, permits a provider of routine health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. Acceptance of surrogate decision making is not mandatory, and is applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions,¹ because of mental retardation or developmental disability.²

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Also effective March 1, 2000, Tennessee Code required inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity. The committee may not, however, over-ride the decision of the recipient's guardian or conservator.¹

¹ See TDMHDD Rule 0940.0001.

² Tennessee Code Annotated § 33-3-218 through 220.

³ Tennessee Code Annotated § 33-6-107 et seq.

Assessment and Diagnosis

Overview

Psychiatric and behavioral assessment of persons with MR includes:

- Comprehensive assessment of MR.
- Assessment of mental illness in persons with mental retardation, including comprehensive history, service recipient interview, medical review and diagnostic formulation.

Diagnosis of MR (Considerations, based on DSM-IV and AAMR criteria)

Criteria	Definition										
Significantly sub-average intellectual functioning	IQ approximately 70 or below										
Below average IQ causes limitations in adaptive skills and functioning in at least two of the following areas	Communication, Self-direction, Self-care, Functional academic skills, Home living, Work, Social-interpersonal skills, Leisure, Use of community resources, Health and safety										
Age at onset	Must be evident before age 18										
Levels of severity (DSM-IV)	<table border="1"> <tr> <td>Mild</td><td>IQ 55-70</td></tr> <tr> <td>Moderate</td><td>IQ 40-55</td></tr> <tr> <td>Severe</td><td>IQ 25-40</td></tr> <tr> <td>Profound</td><td>IQ below 25</td></tr> <tr> <td>Unspecified</td><td>Strong presumption, but the individual's intelligence is untestable by standard instrument</td></tr> </table>	Mild	IQ 55-70	Moderate	IQ 40-55	Severe	IQ 25-40	Profound	IQ below 25	Unspecified	Strong presumption, but the individual's intelligence is untestable by standard instrument
Mild	IQ 55-70										
Moderate	IQ 40-55										
Severe	IQ 25-40										
Profound	IQ below 25										
Unspecified	Strong presumption, but the individual's intelligence is untestable by standard instrument										
Levels of supports needed (AAMR)	Intermittent, Limited, Extensive, or Pervasive										
Be cautious in interpreting low IQ in the presence of a psychiatric disorder	Impairment in IQ must precede and not be directly related to psychiatric disorder										

Assessment of Mental Illness in Persons with MR

Mental illness is frequently comorbid with mental retardation, with most prevalence estimates ranging from 30% to 70%. Virtually all categories of mental disorders have been reported in this population.

However so, diagnostic precision, in the presence of MR, is not always feasible, and there is strong consensus opinion that specific psychiatric diagnosis is not routinely and reliably possible in more severe cases of MR. Many practitioners use medication only when there is a specific psychiatric diagnosis.

The psychiatric diagnostic evaluation of persons who have MR is in principle the same as for persons who do not have retardation. The diagnostic approaches are modified, depending on the service recipient's cognitive level and especially communication skills. For persons who have mild MR and good verbal skills the approach does not differ much from diagnosing persons with average cognitive skills. The poorer the communication skills, the more one has to depend on information provided by caregivers familiar with the service recipient and on direct behavioral observations.

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Assessment Methods

Preferred methods of evaluation

Interview with family/caregivers

Medical history and physical examination

Medication and side effects evaluation

Direct observation of behavior

Functional behavioral assessment

Unstructured psychiatric diagnostic interview †

Also consider:

- Standardized rating scales
- Biomedical evaluation, including family, pregnancy, perinatal, developmental, health, social, and educational history; physical and neurodevelopmental examination, and laboratory tests. Laboratory tests are usually indicated by the findings in the history and physical examination and may include chromosomal analysis (including fragile-X by DNA analysis), brain imaging (CT scan, MRI), EEG, urinary amino-acids, blood organic acids and lead level, appropriate biochemical tests for inborn errors of metabolism.
- Standardized testing (e.g. intelligence, neuropsychological, language) ††

† Interview with family/caregivers; MR; for more severe perinatal MR

†† in mild/moderate MR only

Recipient and Caregiver Interview

The recipient may present communication deficits or may otherwise be shy in regard to disclosure of relevant history. Information from parents and caregivers should always be sought in order to develop a more complete assessment, especially in those instances where the recipient lacks adequate communication skills. Attempts should be made to collect both anecdotal subjective information and more objective data, such as daily record keeping or graphical data.

Comprehensive History Includes:

- Presenting symptoms/behaviors
- Assessment of functioning.
- Treatment history
- Placements and supports
- Family/household dynamics
- Past evaluations.

Recipient Interview:

- Ample time should be allotted for the service recipient interview. Sufficient time is needed to put the service recipient at ease.
- The interview should be adapted to the service recipient's communication skills
- Clear and concrete language should be used
- Reassurance and support should be provided
- Leading and yes/no questions should be avoided
- The interviewer should attempt to ensure that questions are understood
- Mental status may be assessed from context of conversation, rather than by formal examination

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- Nonverbal expression and activity should be considered

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- Medical Review
 - Developmental history
 - Medical history
 - General medical disorders and treatments.

Evaluation of Stressors

Complete evaluation and individualized treatment requires attention to possible stressors that may be triggering or exacerbating the presenting problem in someone with MR. The stressors listed below may be more likely to occur in persons with MR, and cause difficulties for those who have reduced coping skills. Helping the individual, family, and caregivers deal with or eliminate stressors may sometimes be the primary target of treatment and often facilitates whatever other treatment interventions that are necessary.

Type of Stressor	Examples
Change	Moving, new school or job, change of routine, developmental milestones, <i>transition from developmental centers</i>
Interpersonal	Loss of significant other, displacement from job or school
Environmental	Crowding, noise, disorder, lack of stimulation, lack of privacy, work or school-related pressure
Parenting/Social Support	Lack of support from others, disruptive visits/contacts, neglect, hostility, physical or sexual abuse
Illness/Disability	Chronic illness, serious acute illness, sensory deficits, difficulty with ambulation, seizures
Stigmatization re problems	Being taunted, teased, excluded, bullied, or exploited
Frustration	Inability to communicate needs & wishes, lack of choice in living & work situations, self-awareness of deficits
Trauma	<i>Persons with mental retardation have higher rates of victimization</i>

Treatment**Generally**

The habilitation of persons with MR is based on the principles of normalization and community based care, with additional supports as needed. Federal legislation, for example, the Individuals with Disabilities Education Act (IDEA), entitles disabled children and adolescents to a full range of diagnostic, educational and support services from birth to age 21. Specialized treatments are also provided if necessary, as is done for persons with severe visual and auditory impairment.

The parents of children and adolescents with MR are entitled by these laws to receive support services and to be active participants in treatment planning. Some parents and older patients are not aware of their rights to obtain services. The clinician has an important role in such instances to educate and, if needed, to refer to a "patient advocate" or "educational advocate."

In recent practice, children and adolescents are educated in special classes in regular school or in inclusionary programs (in age appropriate regular classes, with additional supports as needed). In the United States, children with MR are now rarely if ever placed in residential institutions and separate schools. Adults with MR of all levels live in the community, in settings varying from their own

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apartments with supports as needed, to small shared living situations. They are employed in specialized settings or, increasingly, in the competitive job market. Habilitation and treatment include:

- Specific treatment of the underlying condition, if known, to prevent or to minimize brain insults that result in MR (e.g., shunting in the case of hydrocephalus).
- Early intervention, education, and ancillary therapies (such as physical, occupational, language therapies, *and behavior therapies*), family support, and other services, as needed.
- Treatment of comorbid physical conditions, such as hypothyroidism, congenital cataracts or heart defects in children with Down syndrome, treatment of seizures in persons with tuberous sclerosis, etc.
- Psychiatric treatment of comorbid mental disorders, including psychosocial interventions and pharmacotherapy.

Psychiatric Treatment

The approach to treatment of mental illness in persons with MR is generally the same as for persons without MR. Modifications of treatment may be necessary, according to the individual's circumstance. Persons with Down syndrome, e.g., may be exquisitely sensitive to anticholinergic drugs, and some persons with MR may be more sensitive to the disinhibiting effects of sedative/hypnotic agents.

Medical, habilitative, and educational interventions should be coordinated within an overall treatment program. Medication should be integrated as part of a comprehensive treatment plan that includes, appropriate behavior planning, behavior monitoring, and communication between the prescribing physician, therapists, and others providing supports, habilitative services, and general medical treatment.

Medication decisions should be appropriate to the diagnosis of record, based upon specific indications, and not made in lieu of other treatments or supports that the individual needs. There should be an effort, over time, to adjust medication doses to document ongoing need or the minimum dose at which a medication remains effective.

Medication decisions need to be based upon adequate information, including medication history and consideration of the individual's complete, current regimen. Medication decisions need to be made with due consideration for potential problems of polypharmacy, and otherwise for negative impact on the individual's functioning and overall quality of life. Every effort should be made to avoid unnecessary compromise of cognitive function or exacerbation of ataxia. Risk vs. benefit needs to be considered and continually reassessed, and justification should be provided, where the benefit of a medication comes with certain risks or negative consequences.

Behavioral Emergencies

- Restraint of any kind, where permitted, is used only when efforts at redirection have failed and the service recipient poses an imminent risk of harm to self or others.
- Emergency medications, where permitted, are given only after appropriate diagnostic assessment and other alternatives are contraindicated.

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- Possible medical causes for an acute behavioral exacerbation must be considered (e.g., other illness, injury, medication side effects)
- Reassessment of the diagnosis and the plan of treatment and support are indicated when there is an emergent behavioral episode

Psychotherapeutic Interventions

Psychotherapy can be effective for persons with MR, toward realization of a variety of goals:

- Mitigation of stressors
- Improved coping skills
- Improved communication of feelings, problems, etc.
- Improved problem solving skills
- Improved social and interpersonal skills
- Reduction/elimination of maladaptive behaviors
- Increase of adaptive behaviors
- Understanding of disability and illness
- Increased self-esteem

Modality and Technique

Group, individual, or family psychotherapy may be appropriate for persons with MR. As with psychiatric care, the approach to treatment of mental illness in persons with MR is generally the same as for persons without MR. Techniques typically utilized with persons with mental illness can be considered potential interventions for persons who are dually diagnosed, with adaptations made as necessary, based on the needs and strengths of the individual. The approach to therapy may need to be more concrete, repetitive, and/or directive, and may need to incorporate visual and auditory aids. Role play can be effective, and behavior modification techniques, such as positive reinforcement are very important.

Generally, the lower the cognitive and adaptive functioning of the person(s), the more extensive the modifications which will need to be made in technique. Some techniques are rarely appropriate for persons who function at the lower levels of mental retardation.

Group therapy in particular can be an invaluable treatment approach for a wide range of emotional, behavioral and life problems. Group therapy uses the power of group dynamics and peer interaction to promote learning and development of new skills among individual group members. Group therapy can be in promoting skills in decision making, problem solving, expression of feelings, socialization, communication, and in maintaining behavioral change.

Family therapy typically focuses on the parents' identification and support of their child's strengths and independence, and the provision of opportunities for success. Parents of recently diagnosed children need careful explanation of their child's condition. Concrete advice in management and resource finding is important, as well as help in obtaining educational supports to which the child is entitled under federal and local laws. Parents of adolescents and young adults need help in coming to terms with emergent sexuality, and in emotionally separating and preparing them to move to out-of-family living in the community.

Behavior Therapy is based upon scientific principles of behavior and uses a functional assessment to understand the variables that influence the behavior. Generally, to be effective, behavior therapy should

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be applied in all settings, and include an emphasis on increasing functional replacement skills, along with the reduction of the maladaptive behavior. This approach may include adjusting the environment to reduce physical and social conditions that seem to trigger maladaptive behaviors, and various specific techniques, such as systematic desensitization, progress relaxation, anger management, assertiveness training, and training more effective social and interactional skills.

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Conjoint Therapy with or without the child present may be used to address specific behavioral issues, and allows parents or caregivers to report their observations frankly. Parents or caregivers can be supported in their efforts at behavior management, which may otherwise tend to be transitory.

Treatment Follow-up

A common problem in the treatment of persons with MR is assessing its effectiveness, which may be viewed differently by various caregivers. Therefore, discrete treatment goals should be agreed upon by the clinician and caregivers, as well as target or "index" symptoms. Interdisciplinary collaboration of professionals and caregivers is essential. Various mental health clinicians might function in the team as direct care providers, team leaders, or consultants to other professionals. Among them, clinicians with medically and psychologically oriented training are often prepared to function as synthesizers of treatment modalities of various disciplines. Follow-up includes service recipient interview/observation and obtaining comprehensive interim information. If the service recipient is not experiencing improvement, the accuracy and completeness of the biopsychosocial diagnosis should be reviewed, as well as the consistency of implementation of treatment by the caregivers.

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TDMHDD Guideline
ADD/ADHD

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TDMHDD Guideline**PROTOCOL FOR THE EVALUATION AND TREATMENT OF
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER****INTRODUCTION**

The guidelines presented here are designed to assist in the evaluation and treatment of children between 5 and 12 years of age with "typical" ADHD in the primary care office. They are based on current understanding of the disorder and coordinate with recommendations from professional organizations, primarily the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry. The goal of the protocol is to improve the care of children with this disorder. It is not intended to dictate treatment decisions but to provide practitioners, especially those in primary care, with information and support as they care for children with ADHD. Complex cases, cases with significant co-morbidity or presentations outside the "typical" age range are beyond the scope of this protocol. Nonetheless the protocol may serve as a base for modifications in these complicated cases.

Informed Consent

Informed, voluntary consent, based upon appropriate information, must be obtained from the service recipient, if he or she has the capacity to give it, or otherwise from a legally authorized representative.

Capacity to give informed consent

Clinicians should consider whether the service recipient, if age 16 or over, is capable of giving informed consent, prior to rendering services, and, if applicable, determine who is legally authorized to make decisions about the service recipient's care.

Tennessee law, effective March 1, 2000, permits a provider of routine health care services to accept the decision of a surrogate, in lieu of a service recipient, where the recipient has no guardian or conservator. Acceptance of surrogate decision making is not mandatory, and is applicable only when the service recipient is reasonably determined to lack capacity to make treatment decisions,¹ because of mental retardation or developmental disability.²

Also effective March 1, 2000, Tennessee Code requires inpatient mental health service providers to maintain treatment review committees for service recipients admitted to inpatient facilities who lack capacity. The committee may not, however, over-ride the decision of the recipient's guardian or conservator.³

¹ See TDMHDD Rule 0940.0000.

² Tennessee Code Annotated § 33-1-218 through 220.

³ Tennessee Code Annotated § 33-6-107 et seq.

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ADD/ADHD

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IN A CHILD BETWEEN 5 AND 12 YEARS OLD WHO PRESENTS WITH
CHIEF COMPLAINT OF:

School problems
Can't stay in seat
Difficulty taking turns
Can't follow instructions
Difficulty completing tasks
Interrupts, intrudes on others
Accident-prone
Difficulty being calm

Over active: fidgety restless
Easily distracted
Blurts out answers
Disruptive behavior
Talks excessively
Acts without thinking
Poor self esteem
"Someone thinks he has ADHD"

CONSIDER ADHD BY USING DSM IV CRITERIA:

CHECK ALL THAT APPLY:

At least 6 of the following symptoms of inattention have been present for at least 6 months *to a degree that is maladaptive and inconsistent with developmental level*:

- ☐ often fails to give close attention to details or makes careless mistakes in schoolwork
- ☐ often has difficulty in sustaining attention in tasks or play activities
- ☐ often does not seem to listen when spoken to directly
- ☐ often does not follow through on instructions and fails to finish schoolwork, chores (not due to oppositional behavior or failure to understand instructions)
- ☐ often has difficulty organizing tasks and activities
- ☐ often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (ex: schoolwork, homework)
- ☐ often loses things necessary for tasks or activities (toys, assignments, pencils, books)
- ☐ is often easily distracted by environmental stimuli
- ☐ is often forgetful in daily activities

OR

At least 6 of the following symptoms of hyperactivity and impulsivity have been present for at least 6 months *to a degree that is maladaptive and inconsistent with developmental level*:

- ☐ often fidgets with hands or feet or squirms in seat
- ☐ often leaves seat in classroom or in other situations in which remaining seated is expected
- ☐ often runs about or climbs excessively in situations in which it is inappropriate
- ☐ often has difficulty playing or engaging in leisure activities quietly
- ☐ is often "on the go" or often acts as if "driven by a motor"
- ☐ often talks excessively
- ☐ often blurts out answers before questions have been completed
- ☐ often has difficulty waiting turn
- ☐ often interrupts or intrudes on others (butts into conversations or games)

AND

☐ Some hyperactive, impulsive or inattentive symptoms *that caused impairment* were present before age 7 years

AND

☐ Some impairment from the symptoms is present in two or more settings (ex: school and home)

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AND

___ There is *clear evidence* of clinically significant impairment in social, academic or occupational functioning

AND

___ The symptoms do not occur only during a psychotic disorder or are not better accounted for by another mental disorder (ex: Mood Disorder, Anxiety Disorder, etc.)

CONFIRM DIAGNOSIS OF ADHD WITH DIRECT INFORMATION FROM PARENTS AND TEACHERS OR OTHER CAREGIVERS:

Request completion of ADHD-specific rating scales (ex.: Abbreviated Conners Scale) by parents and teachers.

Review school-based multidisciplinary evaluations or other school reports and assessments.

EVALUATE PRESENCE OF CO-MORBID CONDITIONS:

Learning Disabilities may exist where there is irregular achievement on school or when academic functioning is less than might be expected based on patient's overall intellect. Refer for psycho-educational testing to confirm.

Oppositional Defiant Disorder and **Conduct Disorder** may co-occur with ADHD in about 30% of patients. Hallmarks include high levels of defiance or other severely disruptive behavior beyond overactivity and poor attention skills. Consider consultation or referral to mental health care provider for diagnosis and treatment.

Anxiety Disorders with prominent worries, fears and tension may co-exist with ADHD. The restlessness and fidgetiness of Anxiety Disorders may resemble ADHD and should be considered in the differential diagnosis. Consider consultation or referral to mental health care provider.

Depressive Disorders may co-exist with ADHD, especially in patients who have experienced numerous failures or other stresses and have developed depressive thought patterns that begin to influence their outlooks. Some of these children may respond to support and experiencing success instead of failure. Others may require consultation or referral to mental health care provider.

Various **social stressors** including adjustment problems, family disruption or physical and sexual abuse can both co-exist and resemble the symptoms of ADHD. A careful and complete social history should be completed. Referral to mental health care providers or other agencies may be needed.

DISCUSS TREATMENT OPTIONS WITH PATIENT AND FAMILY:

Treatment should be **multi-dimensional** and include education, counseling, classroom/school modifications and medication depending on the specific needs of each individual child and family.

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The child and parents should be educated about the diagnosis and encouraged to understand this represents a challenge to overcome, not an "excuse" for misbehavior. Strengths and relative weaknesses should be identified. The variations in the presentation and the course of the disorder should be reviewed. Encouraging parents to become advocates for their child and informing them of their options is a part of education that may be done in the primary care office.

Various forms of counseling may be the major intervention for mild cases of ADHD. **Behavioral therapy** can be used to modify behavior using behavioral plans which target specific behavior, outline rewards and address how the plan is to be modified after success. **Family therapy** can be used to change family interactional patterns that may cause dysfunction and improve communication and other family functions to encourage the child with ADHD to rely upon his strengths. The family discipline system should be analyzed and modified in ways acceptable to all participants. Various forms of **individual counseling** may be indicated for children with problems coping or other co-morbid conditions. While general behavioral therapy may be done in the primary care office, other, more formal counseling and therapy, should be referred to a mental health care provider.

CONSIDER A TRIAL OF MEDICATION:**Plan A:**

Stimulant medications, either methylphenidate (Ritalin) or amphetamine (Dexedrine, Adderall), are first line medications in the treatment of ADHD. Discuss the indications, possible side effects (decreased appetite, sleep disturbance, headaches, moodiness) and an overall treatment plan with the parents. If consent is obtained begin treatment with low doses of stimulant medication in two to three daily divided doses, each about three to four hours apart (ex: 8AM, 12 N, 4PM).

Based on response and side effects, the dose can be adjusted fairly rapidly, once a week, to a maximum of 2mg/kg/day or 60mg/day of methylphenidate or 1mg/kg/day or 60mg/day of an amphetamine preparation. Most children with ADHD require doses less than the maximum. Lack of response to near maximum doses indicates a need to review the diagnosis and/or consideration of another medication.

Periodic follow up by phone calls and/or office visits should address response, compliance, side effects and overall functioning. Information for school staff is very useful in monitoring response to medications.

If a good response to first line stimulant is documented, changing to a long acting preparation of the same stimulant may be indicated for convenience and improved compliance.

Consideration should be given to "medication holidays", periods off medication. The indications for these are debatable. However, in consideration of parental desires, the severity of patient symptoms and the activities in which the child participates (ex: summer vacation may not be a good time for medication holiday for a child who is taking classes in summer school) medication-free periods may be desirable. Some knowledge about continued need for medication may be gained during these periods.

If poor response is seen to first line stimulant, go to Plan B.

Plan B.

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Lack of response to one stimulant does not indicate poor response to other stimulant medications. Therefore, start treatment with a second stimulant medication (amphetamine, if methylphenidate used in Plan A or vice versa). Methods of dosing and monitoring follow up are as in Plan A.

If poor response is seen, consider Plan C.

Plan C:

Consider treatment with pemoline (Cylert) a third available stimulant. Because of rare, fatal liver toxicity some clinicians may elect to bypass this step. Because of a longer half-life, once a day dosing is possible. Doses begin at 18.75 mg and may be increased in two to three weeks depending on response and side effects. Due to the longer half-life, response may take one to two weeks to occur. Frequent laboratory monitoring of hepatic enzymes (every two to three weeks) can be problematic and limits this option.

Plan D is considered by clinicians that opt against Plan C or for patients that do not respond to pemoline.

Plan D:

Tricyclic antidepressant medications have been shown to be useful in children with ADHD. Due to side effects, high overdose toxicity and poorer response rates than stimulants, these medications are thought of as third and fourth line medication interventions. Imipramine (Tofranil) is recommended. Due to possibly higher cardiac effects, desipramine (Norpramin) is not recommended. Pretreatment screening should include family history of cardiac arrhythmias, physical exam, general laboratory screens and an EKG. Side effects (sedation, increased appetite, tremors, and cardiovascular symptoms) are discussed with the patient and family. Dosing is started at 25 mg/day in once daily dosing.

The dose is gradually increased based on response and side effects. It may take one to two weeks to observe a clinical response, so dose should not be increased more frequently than weekly. Doses above 2-3mg/kg/day are associated with increased adverse events. Doses higher than this merit reconsideration of the diagnosis and consultation with specialists.

Response, including reports for school staff, should be monitored along with occurrence of side effects and overall functioning. EKG should be monitored throughout treatment, especially at increased doses.

**CONSIDER REFERRAL TO SPECIALIST IN DEVELOPEMETNAL PEDIATRICS
OR CHILD PSYCHAITRY:**

Using these guidelines it is estimated that about 90% of children with ADHD will show significant response in the primary care setting (in conjunction with educational and counseling interventions). Lack of response to these interventions indicates need for re-evaluation and possible referral to specialist in developmental pediatrics or child psychiatry.

Attachment J

Semiannual Review of Appeals



STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TennCare
OFFICE OF GENERAL COUNSEL

Don Sundquist
Governor

Doctor's Building, 5th Floor
706 Church Street
Nashville, Tennessee 37247-0064
(615) 741-1354 / FAX (615) 532-7322

C. Warren Neel
Commissioner

Memorandum

TO: Linda Ross
Attorney General's Office

FROM: Betty F. Boner *BFB*
Deputy General Counsel

DATE: July 18, 2001

SUBJECT: EPSDT REPORT (January-June 2001)

The number of appeals reflected may not include all appeals received during this time period, as these numbers are dependent on the data pulls. Data for this report was pulled July 7, 2001.

For each MCO/BHO, the table below reflects the total number of children's appeals for January - June 2001.

MCO/BHO	January - June 2001 TOTAL # OF CHILDREN'S APPEALS
Access MedPlus	2392
DMR	30
John Deere	150
OmniCare	273
PHP	380
Prudential	3
TLC	447
VHP	49
VSHP	3699
Xantus	985
Other	7
TOTAL	8415
Premier	415
TBH	175
TOTAL	590
GRAND TOTAL	9005

Based on a compilation of Service appeals data for January-June 2001, there were a total of 9005 appeals filed on behalf of children (under 21 years of age). Eight thousand two hundred five (8205) were regular appeals and eight hundred (800) were expedited appeals. As of July 7, 2001 four thousand six hundred sixty-three (4663) of these appeals are still pending a final resolution.

CARE TYPES

Children's appeals included 31 service types. The Service Types with the highest number of appeals are: Pharmacy (2193), Reimbursement (492), Access to Service (430), Other (313), Dental (258), Residential Treatment – Child (221), and Physician (100),

Additional Care Types include: Procedure (59), DME (55), MH-Inpatient (55), Eligibility (22), MR Waiver (21), Home Health (19), A&D (19), Therapeutic Foster Care (17), MH-Outpatient (13), Vision (9), Independent Living (7), Psychiatric Evaluation (7), Physical Therapy (6), Occupational Therapy (5), Speech Therapy (4), Methadone Treatment (3), Transportation (3), Hospital (2), Rehabilitation (2), Emergency (2), Drug Approval (1), Nutritional (1), Service (1), and Quality (1).

TYPE OF SERVICE, MCO/BHO

MCO/BHO NAME	TYPE OF SERVICE
Access Med Plus	Pending (1106), Pharmacy (679), Access to Services (248), Dental (122), Reimbursement (105), Other (71), Physician (35), Procedure (6), Vision (5), Eligibility (4), DME (4), Home Health (3), Occupational Therapy (1), Physical Therapy (2), Speech Therapy (1)
Department of Mental Retardation	MR Waiver (21), Pending (9).
John Deere	Pending (68), Pharmacy (24), Reimbursement (17), Access to Services (16), Other (13), DME (3), Dental (2), Home Health (2), Procedure (2), Drug Approval (1), Eligibility (1), Physical Therapy (1).
Omni Care	Pending (120), Pharmacy (96), Other (22), Reimbursement (11), Dental (7), Access to Services (5), Procedure (5), Physician (3), Eligibility (2), Home Health (1), DME (1).
Prudential	Reimbursement (2), Pending (1).
TLC Family Care Health Plan	Pending (206), Pharmacy (155), Reimbursement (28), Other (28), Dental (18), DME (4), Home Health (2), Access to Services (2), Physician (2), Eligibility (1), Physical Therapy (1).
VHP Community Care	Pending (30), Reimbursement (5), Other (5), Pharmacy (5), Access to Services (2), Dental (1), Vision (1).
VSHP	Pending (2343), Pharmacy (789), Reimbursement (206), Access to Services (111), Other (85), Dental (54), Procedure (40), DME (28), Physician (20), Eligibility (9), Home Health (7), Physical

VSHP Cont.	Therapy (2), Emergency (1), Nutritional (1), Service (1), Occupational Therapy (1), Quality (1).
Xantus	Pending (430), Pharmacy (336), Reimbursement (54), Dental (44), Physician (38), Other (35), Access to Services (21), DME (12), Vision (3), Occupational Therapy (3), Speech Therapy (3), MH-Inpatient (2), Eligibility (1), Home Health (1), Procedure (1), Rehabilitation (1).
Other	Eligibility (3), Reimbursement (2), Pending (2).
Premier	Residential Treatment (155), Pending (114), MH-Inpatient (39), Other (20), Pharmacy (13), A&D (13), Therapeutic Foster Care (13), Reimbursement (12), MH-Outpatient (11), Psychiatric Evaluation (6), Independent Living (5), Access to Services (4), Transportation (3), Home Health (2), Hospital Inpatient (2), Eligibility (1), Emergency Services (1), Provider Payments (1).
TBH	Residential Treatment (66), Pending (41), Other (20), MH-Inpatient (14), Reimbursement (6), A&D (6), Access to Services (5), Pharmacy (5), Therapeutic Foster Care (4), Methadone Treatment (3), Independent Living (2), MH-Outpatient (2), Psychiatric Evaluation (1).

APPEALS RESOLUTIONS

MCO/BHO DECISION	TOTAL	APPEAL UNIT DECISION	TOTAL
Affirmed	5741	Affirmed	95
		Case Withdrawn by Enrollee	30
		Informal Resolution	339
		Reversed	500
		Pending	4661
		Directive Issued	81
		Transferred	33
		Cont. By Petitioner	2
Total	5741	Total	5741
Case withdrawn by enrollee	20	No Decision Required	20
Informal Resolution by Agreement	769	No Decision Required	769
Reversed	2435	No Decision Required	2435
Service Approved	40	No Decision Required	40
Grand Total	9005	Grand Total	9005